

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 & 15 Form G-382-11-78/66mb

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Frederick MARYLAND		a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pennsylvania Somerset		
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
One week		Rural Rockwood 75-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Frederick Memorial Hospital		Rt. # 2		
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle LEE	Last BAER	
4. DATE OF DEATH	Month Nov.	Day 6	Year 1966	
5. SEX M	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1931	
9. AGE (In years last birthday) 35 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Veteran	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Leo Baer	14. MOTHER'S MAIDEN NAME Irene Thomas	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 728-03-8418	17. INFORMANT Mary C. Baer (same) wife	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 345X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		chronic Pyelonephritis = Renal Failure 10 weeks		
(b) DUE TO		Multiple Sclerosis = Cord Bladder 10 years +		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 31, 1966, to Nov. 6, 1966, that (I) (we) last saw the deceased alive on Nov. 6, 1966, and that death occurred at 5 PM, from the causes and on the date stated above.		22b. DATE SIGNED Nov. 6, 1966		
22a. SIGNATURE W. J. Riddick		22c. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. ADDRESS Frederick Medical Center, Frederick, Md.		
22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 10, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. Philips & James Catholic Cemetery	23d. LOCATION (City, town or county) (State) Meyersdale, Pa.
24. FUNERAL DIRECTOR Ronald M. ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
M. R. Etchison & Son, Frederick, Maryland		DATE NOV 10 1966 Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15619**CERTIFICATE OF DEATH****15622**

10. HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or attending physician.		The law requires that the death certificate be executed within 24 hours after death.								
11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.										
										1. PLACE OF DEATH a. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 6 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 519 North Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 519 North Market Street		e. DATE OF DEATH November 30, 1966		f. MONTH November		g. DAY 30
3. NAME OF DECEASED (Type or print)		First MARY	Middle BELL	Last BARNHOUSE	4. DATE OF DEATH November 30, 1966	Month November	Day 30	Year 1966		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8 June 1893	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Calvin Boone		14. MOTHER'S MAIDEN NAME Liza Sickle								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 12 0021B		17. INFORMANT James W. Barnhouse (Same as item #1)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 6 weeks								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>arteriosclerotic Heart Disease</i>								
420.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension & Infarction 5 weeks ago</i>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)						
19										
21. I certify that (I) (this hospital) attended the deceased from May 13, 1966 to 11-30, 1966 , that (I) (we) last saw the deceased alive on 11-30, 1966 , and that death occurred at 3:35 p.m. M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Thomas E. Stone</i>		22b. DATE SIGNED 1 Dec 1966								
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS 4 W. 3rd St., Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery	23d. LOCATION (City, town or county) Frederick, Md. 21701		(State)				
24. FUNERAL DIRECTOR <i>Frank R. Smith Jr.</i>		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR DEC 5 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
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FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15623

I. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -		c. LENGTH OF STAY IN lb Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leesburg R.F.D. 4		d. STREET ADDRESS Route 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nr. Brunswick				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Richard	Middle P.	Last Barnhouse	4. DATE OF DEATH 11	Month	Day 6	Year 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1920	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Highway Dept.		11. BIRTHPLACE (State or foreign country) Loudoun County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Barnhouse				14. MOTHER'S MAIDEN NAME Roberta Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 2		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Fractured Skull, Fractured Spine, Crushed Chest, Lacerated Heart & Lungs, Ruptured Diaphragm; Soc. Liver		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 11-6- 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) Freeway		20f. (City or town) Leesburg (County) Fred - Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-6-66			
EXAMINER'S NAME (Type) B.O. Thomas, Sr.M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B.O. Thomas, Sr.M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) B.O. Thomas, Sr.M.D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/9/66	23c. NAME OF CEMETERY OR CREMATORIAL Bethel	23d. LOCATION (City or Town) Leesburg (County) Loudoun (State) Va.				
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	ADDRESS Tidewater	25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodsboro</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>111</i>	
3. NAME OF DECEASED (Type or print) <i>JOHN LESLIE BIDDINGER</i>		First <i>J</i>	Middle <i>L</i>
4. DATE OF DEATH <i>Nov. 3 1966</i>		Last <i>N</i>	Month <i>Nov.</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 5, 1895</i>		9. AGE (in years last birthday) <i>71 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Biddinger</i>		14. MOTHER'S MAIDEN NAME <i>Ida Eaves</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-01-1252</i>	
17. INFORMANT <i>Mrs Carl Boone, Keymar Rd, Md.</i>		Address <i>112</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral pneumonia, lung lobe</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease with congestive myocardial failure</i> DUE TO (c)		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe anemia, due to hemorrhage etiology undetermined</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1966</i> , to <i>3 Nov. 1966</i> , that (I) (we) last saw the deceased alive on <i>3 Nov. 1966</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>11/4/66</i>	
22e. SIGNATURE <i>James E. Stoner, Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES E. STONER, JR.</i>		22d. ADDRESS <i>WALKERSVILLE, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/6/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel Cem.</i>		23d. LOCATION (City, town or county) <i>M. Libertytown, Md.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>G. S. Barton</i>		ADDRESS <i>Walkersville, Md.</i>	
25e. REC'D BY REGISTRAR DATE <i>NOV 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15622

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove. To be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		a. STATE	Maryland b. COUNTY	
c. LENGTH OF STAY IN lb		4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Monocacy Hall Nursing Home		d. STREET ADDRESS	911 Motter Place	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year	
J.	Adney	Biddle		Nov. 23-	19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 18- 1873	93 yrs.	Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		
Retired- Minister		-----		New Philadelphia- Ohio		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Jonathon Biddle		Polona Reynolds		U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
No		220-44-2422		Mrs. N. Edward Lightner-911 Motter Place-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Frederick- Md.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
422.1		<i>Cerebral thrombosis</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)	<i>Arterio-sclerotic Cardiovascular</i>			
		DUE TO (c)	10+ yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<i>Chronic lymphatic leukemia</i>						
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
19						
21. I certify that (I) (this hospital) attended the deceased from 1962, 19, to 23 Nov, 1966, that (I) (we) last saw the deceased alive on 22 Nov, 1966, and that death occurred at 14:30A, from the causes and on the date stated above.						
22. SIGNATURE <i>Charles H. Conley, Jr.</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Nov. 23-1966
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701				
Dr. Charles H. Conley, Jr.						
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)
Burial		Nov. 25-1966		Mt. Olivet Cemetery Whitmore		Frederick, Md. 21701
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elwood T. M.R. Etchison & Son</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		Frederick, Md. 21701		NOV 28 1966		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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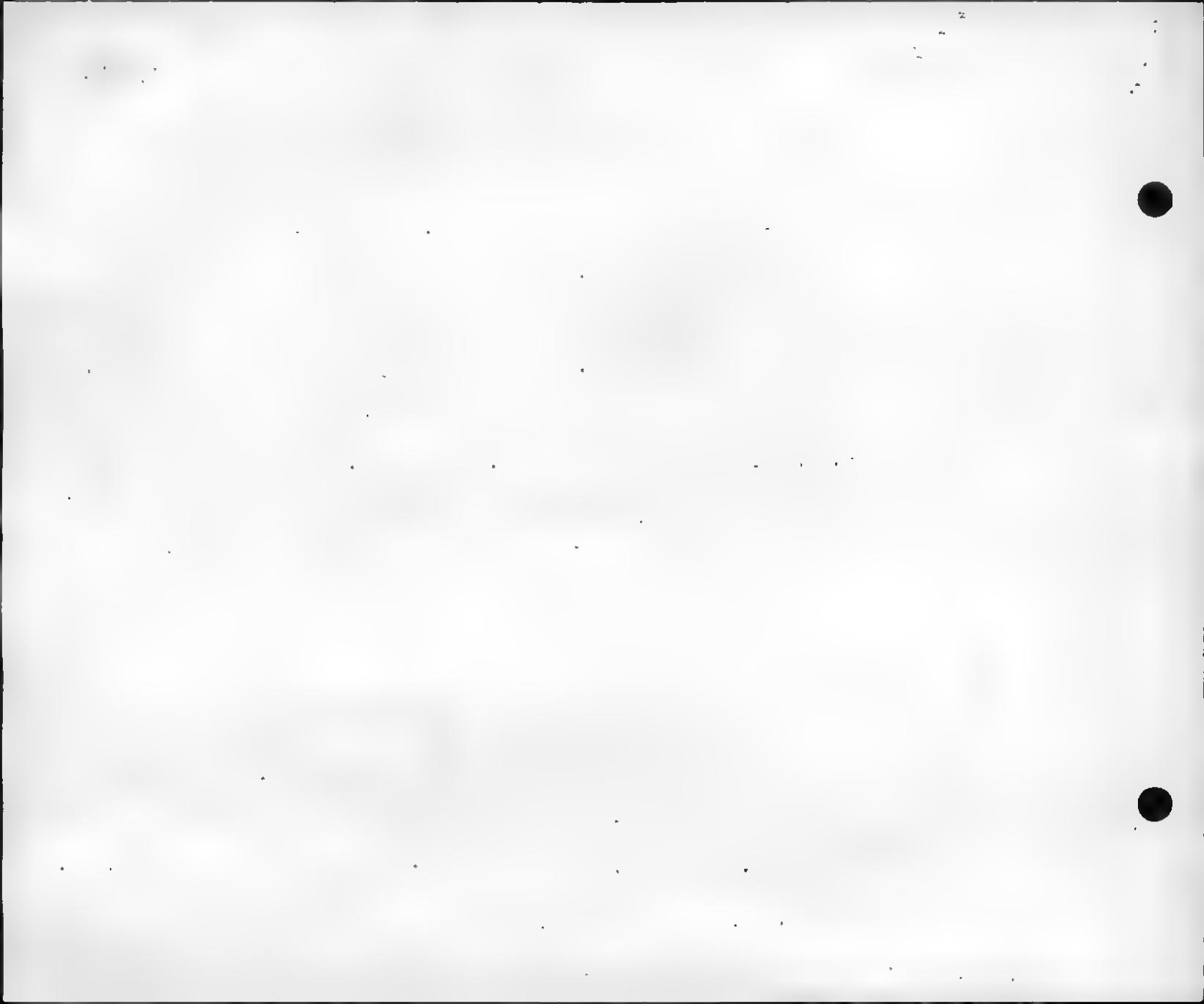
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c LENGTH OF STAY IN lb Hours		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d STREET ADDRESS 135 W. Patrick Street		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First HILLARD	Middle M.	Last BRUST	4 DATE OF DEATH November	Month Day Year 19 19 66
5. SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 10, 1895	9 AGE (In years last birthday) 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Canning Co.		11 BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	
13. FATHER'S NAME Henry Brust			14. MOTHER'S MAIDEN NAME Flora Ann Stull		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) Yes V. V. # 1		16. SOCIAL SECURITY NO 220 01 5641		17. INFORMANT Address Mrs. Margaret N. Brust (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute INTERVAL BETWEEN ONSET AND DEATH 12 hours DOUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerosis (Heart Disease) (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.)	20f (City or town) Frederick	(County) (State) Maryland
21. I certify that (I) (this hospital) attended the deceased from 11/19 1966 to 11/19 1966 that (I) (we) last saw the deceased alive on 11/19 1966 , and that death occurred at 11:15 AM ; from causes and on the date stated above.					
22a. SIGNATURE James B. Thomas,		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 11-19-66		
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market Street, Frederick, Md.			
23a. BURIAL, CREMATION, REMASSAL (Specify) Burial		23b. DATE THEREOF Nov. 22, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City or Town) Frederick, Maryland	
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR NOV 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

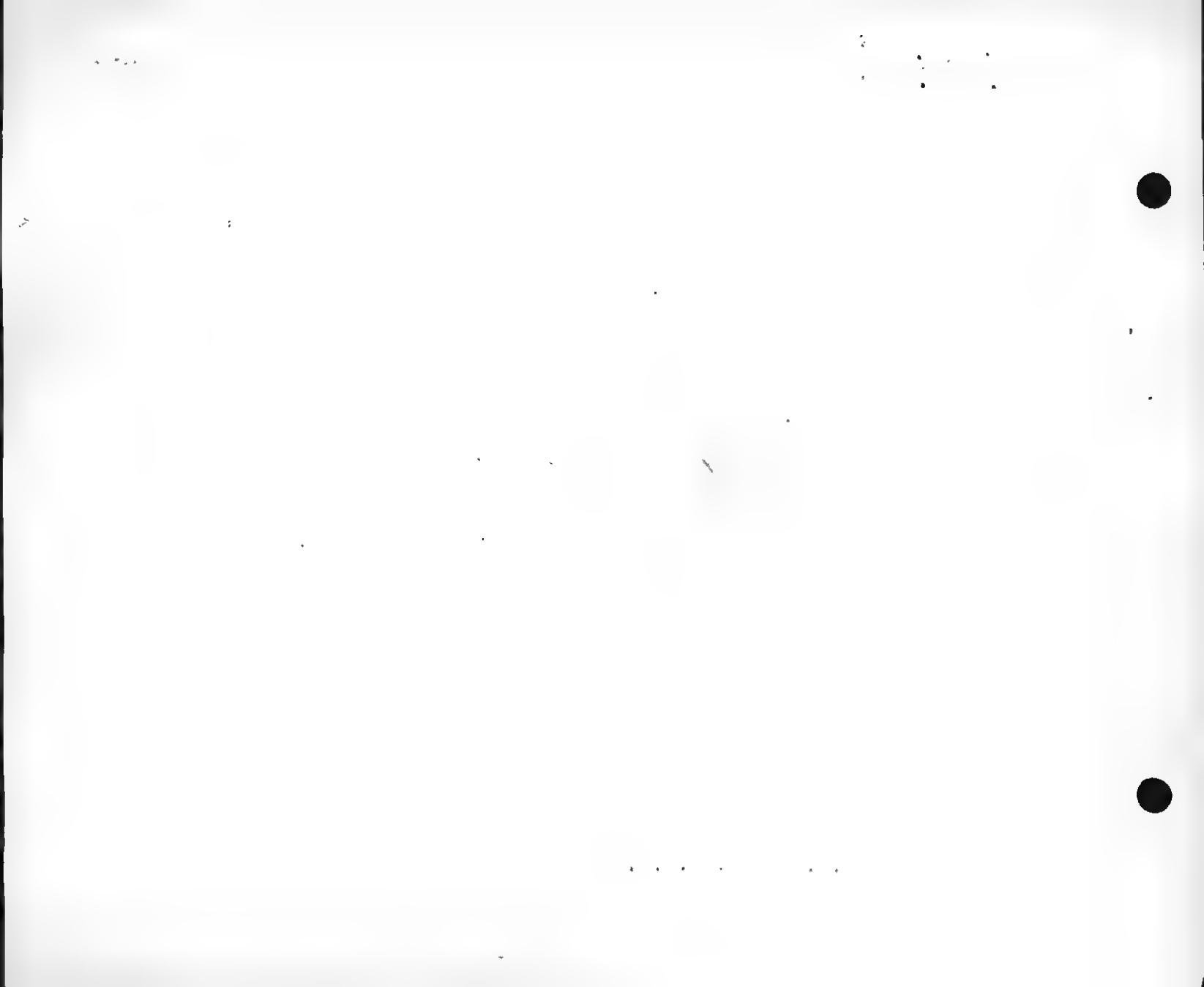
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File page 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15624		15627	
<p>1 PLACE OF DEATH a. COUNTY <i>Frederick</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i></p>		<p>2 USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE <i>Md</i> b. COUNTY <i>Frederick</i></p>	
<p>c. LENGTH OF STAY IN 1b</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Mem.</i></p>		<p>d. STREET ADDRESS <i>619 Lee Place</i></p>	
<p>3 NAME OF DECEASED (Type or print) <i>EDWARD</i></p>		<p>4 DATE OF DEATH <i>NOV. 7 1966</i></p>	
5 SEX <i>M.</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Dec 13, 1911</i>
<p>10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>PHYSICAL Scientist</i></p>		<p>9 AGE (In years last birthday) <i>54 yrs</i></p>	
<p>10b KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i></p>		<p>11 BIRTHPLACE (State or foreign country) <i>Boston Mass.</i></p>	
<p>13 FATHER'S NAME <i>David</i></p>		<p>14 MOTHER'S MAIDEN NAME <i>Sarah Steinberg</i></p>	
<p>15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i></p>		<p>16 SOCIAL SECURITY NO <i>622-16-8256</i></p>	
<p>(If yes give war or dates of service) <i>WW II 1940-1945</i></p>		<p>17 INFORMANT <i>Mildred A. Cherry</i></p>	
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Tamponade - Hemopericardium</i> (b) <i>Ruptured Myocardial Infarct</i> (c) <i>Atherosclerotic Heart Disease</i></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <i>+201</i></p>	
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
<p>20a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</p>		<p>20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</p>	
<p>20c TIME OF INJURY Month, Day, Year Hour a.m. <i>pm</i> 19</p>		<p>20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	<p>20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>
		<p>20f (City or town) <i>Frederick</i> (County) <i>Md</i> (State) <i>Md</i></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspect an <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <i>B.O. Thomas</i></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.</p>	
<p>EXAMINER'S NAME (Type) <i>B.O. Thomas, Sr.M.D.</i></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)</p>	
<p>23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>23b DATE THEREOF <i>11-10-66</i></p>	
<p>23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>SHARON MEMORIAL SALAMONE FUNERAL HOME</i></p>		<p>23d LOCATION (City or Town) <i>SHARON MASS.</i> (County) <i>MASS.</i> (State)</p>	
<p>24 FUNERAL DIRECTOR <i>FREDRICK MD.</i></p>		<p>25a REC'D BY REGISTRAR <i>Charles Judge</i></p>	
		<p>25b REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>	



1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

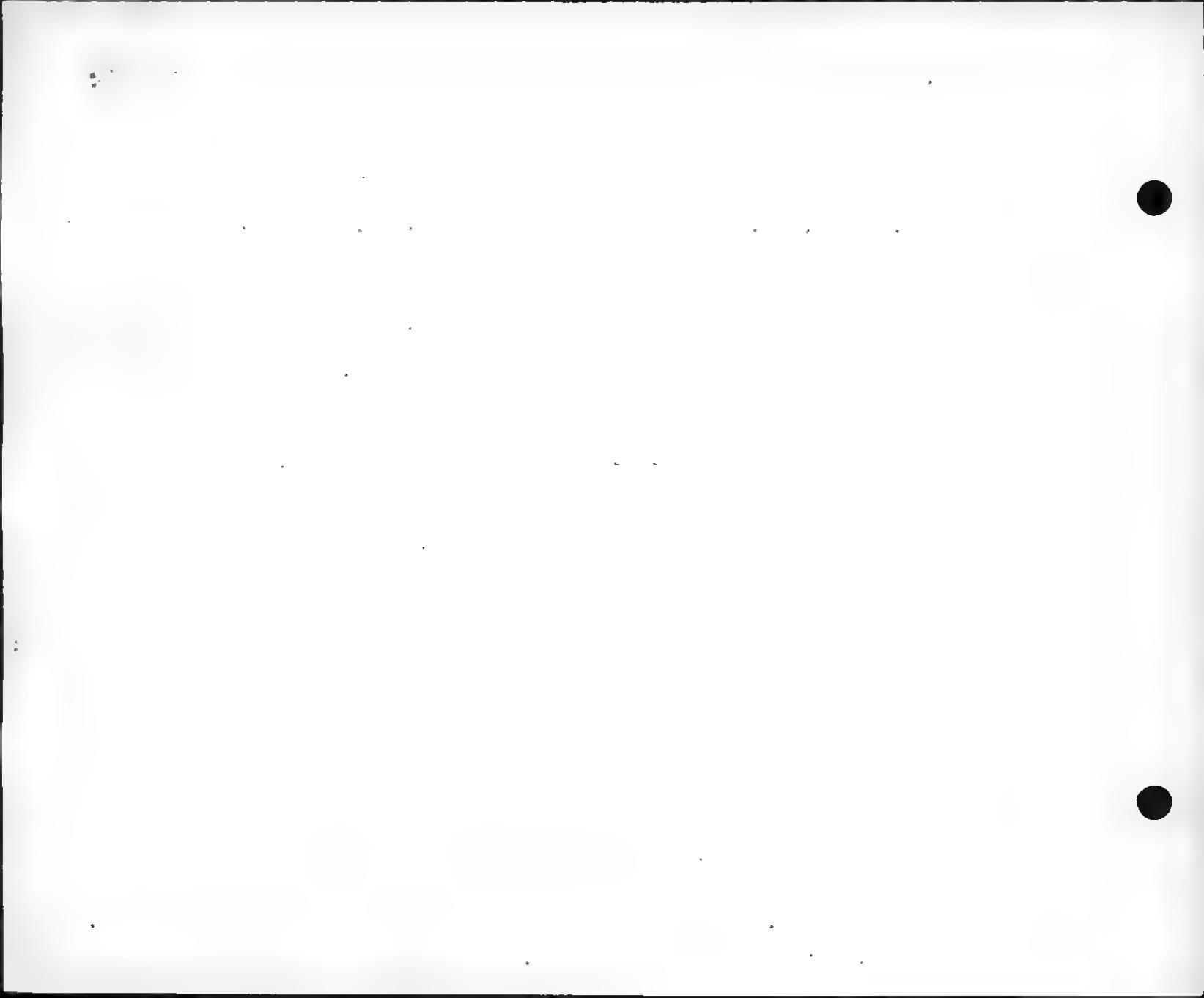
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15628

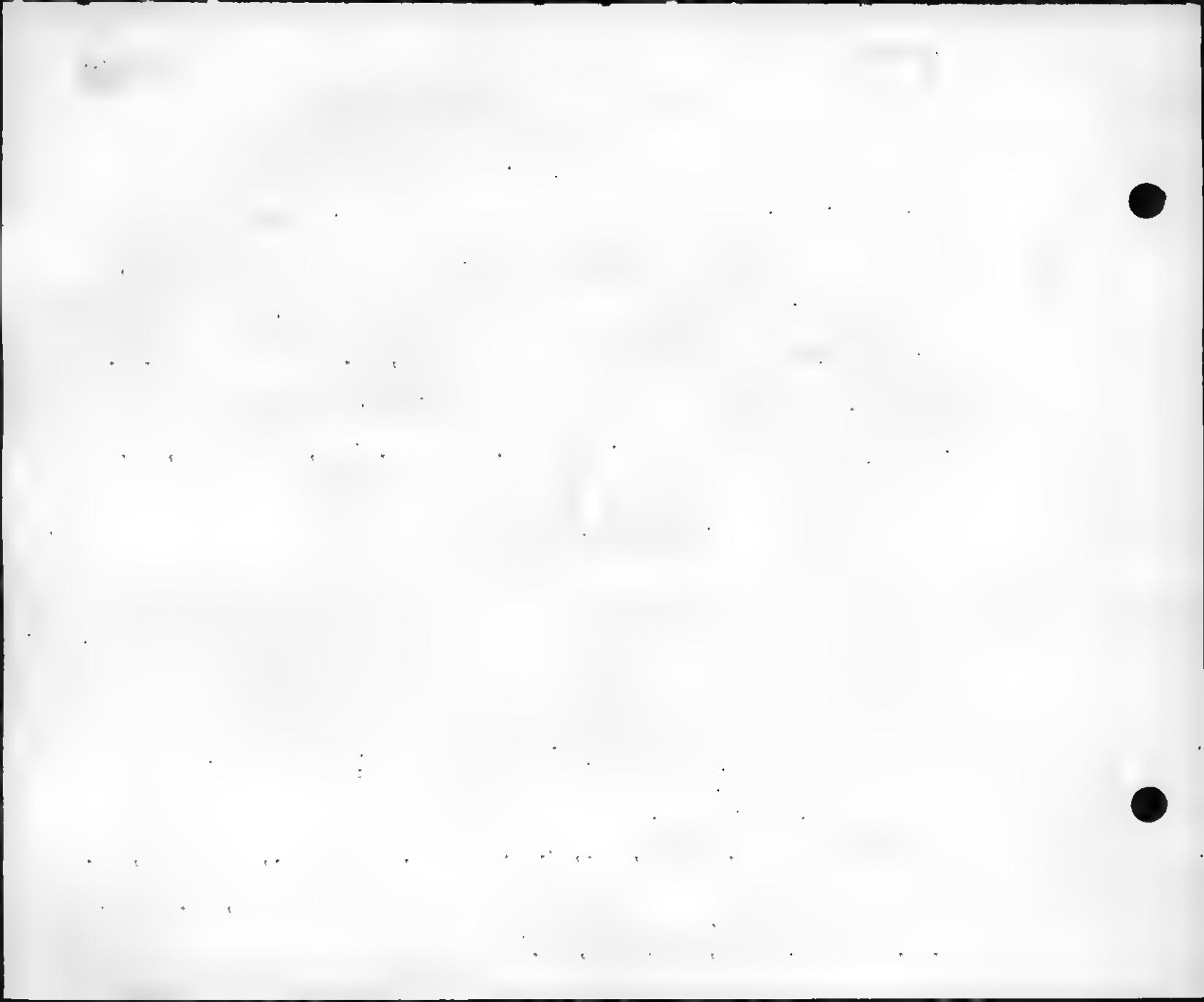
1 PLACE OF DEATH a COUNTY Frederick b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Plane #4		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE Maryland b COUNTY Frederick				
c LENGTH OF STAY IN TB		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Plane #4				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 1, Mt. Airy		d STREET ADDRESS R.F.D. # 1, Mt. Airy				
e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3 NAME OF DECEASED (Type or print) Jesse		First Jesse	Middle Clay			
4 DATE OF DEATH Nov. 12 1966		Month Nov.	Day 12			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH July 15, 1893		9 AGE (In years lost birthday) 73 yrs	F UNDER 1 YEAR Months 0 Days 0			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b KIND OF BUSINESS OR INDUSTRY Own farm	F UNDER 24 HRS Hours 0 Min 0			
11 BIRTHPLACE (State or foreign country) Kempton, Md.		12 CITIZEN OF WHAT COUNTRY? USA				
13 FATHER'S NAME John Nelson Clay		14 MOTHER'S MAIDEN NAME Isabelle Purdum				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-36-2488	17 INFORMANT Address Mrs Bessie V. Clay, Item 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) Arteriosclerotic Heart Disease stating the underlying cause OUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Plane #4	(County) Maryland	(State) MD
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE B.C. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11/12/66		
EXAMINER'S NAME (Type) B.C. Thomas, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Marvin Chapel	23d. LOCATION (City or Town) (County) (State) Plane # 4, Maryland.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE	
				DATE NOV 15 1966		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15626			15629								
1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
2. COUNTY	a. STATE Maryland b. COUNTY Frederick										
Frederick											
MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
Frederick	Since 2/28/63	Frederick									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?							
Monocacy Hall Nursing Home	340 East Third Street			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
	EDGAR	SPONSELLER	CROMWELL	November 29,	1966						
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	22 Nov 1879	87 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Retired-Laborer	Brush Company	Pearl, Md.			U. S.						
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME										
Curtis A. Cromwell	Annie Elizabeth Sponseller										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address								
No	214 10 1996	Mrs. Louise S. Oden, Ijamsville, Md. 21754									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
332X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arterio-sclerosis</i> 16 years (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 15</i> , 1966, to <i>Nov. 21</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov. 20</i> , 1966, and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Bernard O. Thomas Jr.</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 30 Nov 1966		
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.			22d. ADDRESS 228 N. Market St., Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/2/66			23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery			23d. LOCATION (City, town or county) (State) Frederick, Md. 21701		
24. FUNERAL DIRECTOR <i>Frank R. Etchison Jr.</i>			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		
M. R. Etchison & Son, Frederick, Md. 21701						DATE DEC 2 1966					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION
15627

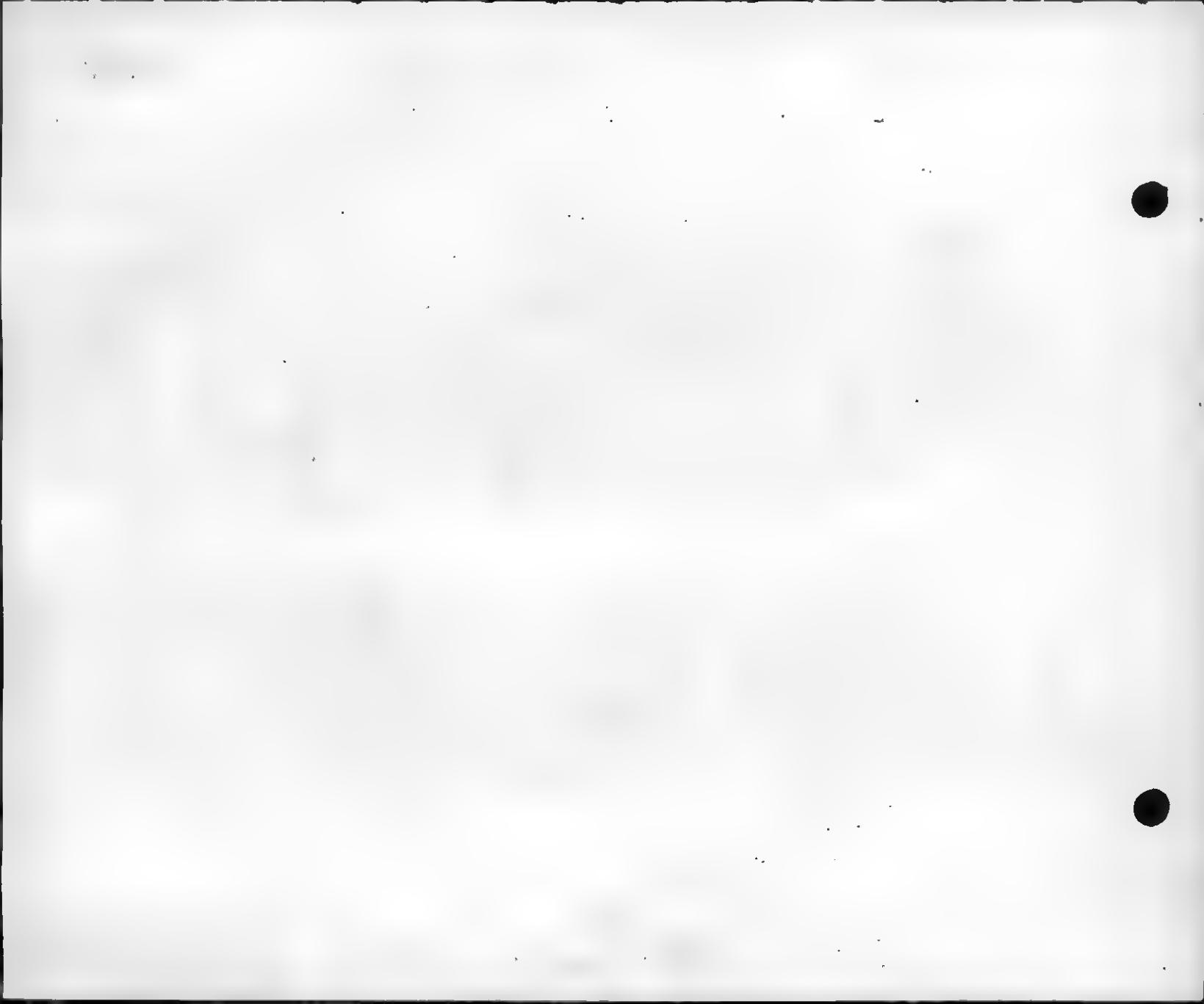
CERTIFICATE OF DEATH

15634

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE <u>MD</u>	
<u>FREDERICK</u>		<u>1 day</u>		b. COUNTY <u>FREDERICK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>FREDERICK MEMORIAL HOSPITAL</u>				<u>WALKERSVILLE</u>	
3. NAME OF DECEASED (Type or print)		First <u>SHERRY</u>	Middle <u>LEE</u>	Last <u>CRUM</u>	4. DATE OF DEATH <u>11 27 1966</u>
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/66</u>	9. AGE (in years last birthday) <u>yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>FREDERICK MD.</u>	
13. FATHER'S NAME <u>GARY WAYNE CRUM</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN FOGLE</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFDRMNT Address <u>MRS. IDA RAMSBURG, WALKERSVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstructive (BW - 567 gm.)</u> INTERVAL BETWEEN ONSET AND DEATH _____ 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 26, 1966</u> to <u>Nov 27, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 17, 1966</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.		22d. DATE SIGNED <u>Nov 27, 1966</u>			
22a. SIGNATURE <u>J. F. Baker</u>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. ADDRESS <u>FREDERICK MD.</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. F. BAKER</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Chapel cemetery</u>		23d. LOCATION (City, town or county) <u>Dr. Libertytown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 11/28/66</u>		23b. DATE THEREOF <u>11/28/66</u>		(State) <u>MD.</u>	
24. FUNERAL DIRECTOR <u>J. C. Barton, Walkersville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

SMELL OR LISTENING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dent of Health prior to burial/cremation or removal and in any event within 72 hours after death.



1 M
FOR STATE
HEALTH DEPT.

10 DIVINITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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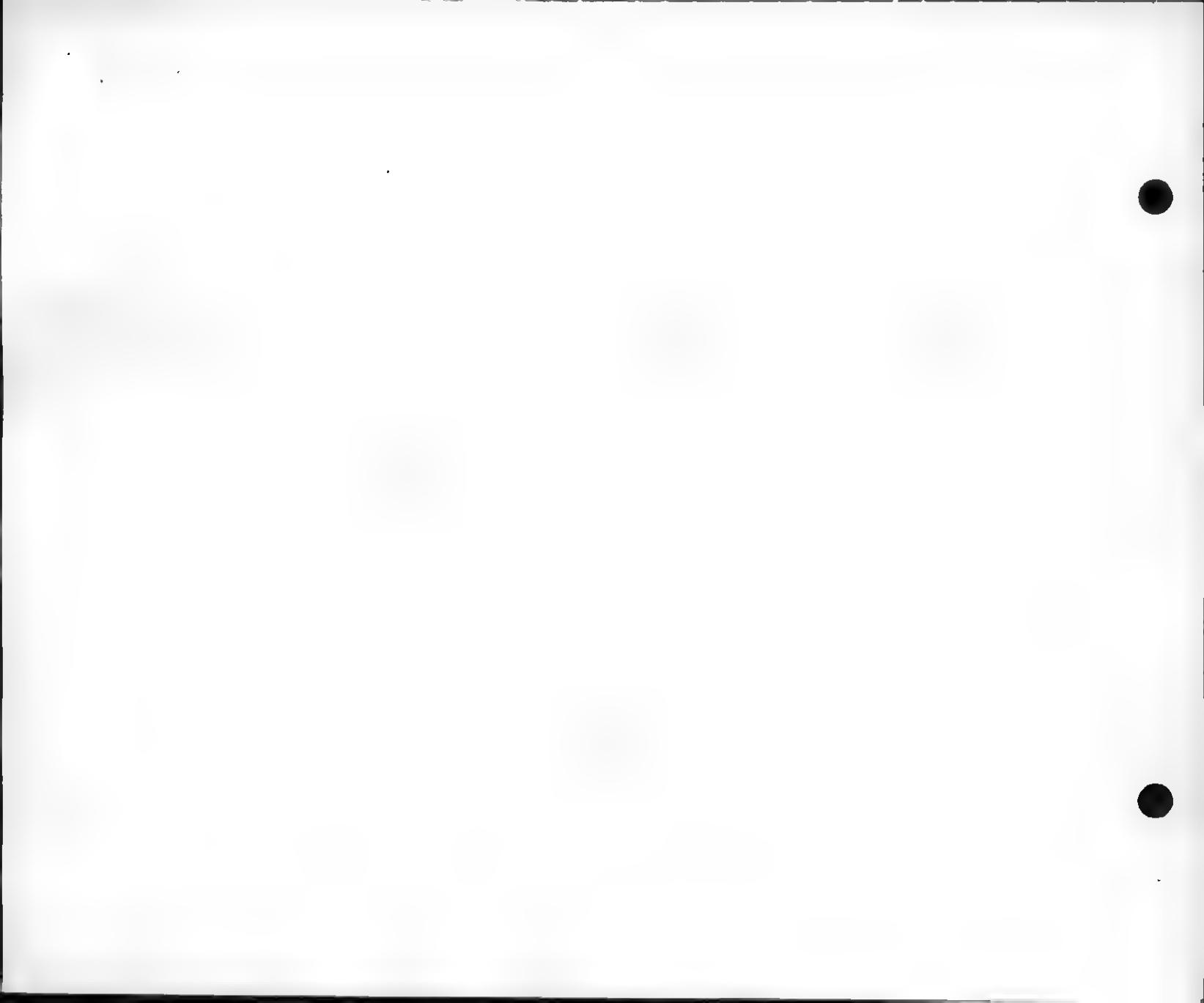
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15631

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first if on residence before admission) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1 Myersville		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1 Myersville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First KENNETH Middle EUGENE Last FISHER		4 DATE OF DEATH Month November Day 24, Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month October Year 1948 Age (In years last birthday) 18 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13 FATHER'S NAME Oscar W. Fisher		14. MOTHER'S MAIDEN NAME Hazel Summers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		16 SOCIAL SECURITY NO 214-48-4298	
17 INFORMANT Linda Lou Fisher,		Address Route #1 Myersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Accidental Gunshot Wounds to Abdomen. DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH Immediate			
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year 3:30 p.m. 11/24 1966		20d. INJURY OCCURRED Wh. a. Not Wh. b. <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Myersville, Fred. Co. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. J. Thomas		22. DATE SIGNED 11/24/66	
EXAMINER'S NAME (Type) B. J. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frederick, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL Harmony Church of Bretheran. Frederick Co. Md.		23d. LOCATION (City or Town) (County) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR NOV 28 1966	
		25b. REGISTRAR'S SIGNATURE J. Lewis George	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15529

CERTIFICATE OF DEATH

15632

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural - Woodsboro 7 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

e. ADDRESS

f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural - Woodsboro

d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED **NEVER MARRIED**

WIDOWED **DIVORCED**

B. DATE OF BIRTH

Nov. 16 1881

9. AGE (In years last birthday)

84 yrs

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hezekiah Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Mary Matilda Smith

Address

Mrs. Glenn H. Fogle, Walkersville, Md

INTERVAL BETWEEN ONSET AND DEATH

2 days

10 years

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

**Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.**

(b)

DUE TO

(c)

Congestive heart failure

Arterio-sclerotic C.V.D.

MEDICAL CERTIFICATION

20e. TIME OF INJURY

Month

Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, term,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

While

Not While

at work

at work

20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]

Cerebral arterio-sclerosis dementia

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, term,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 1, 1966, to Nov 1, 1966, that (I) (we) last

saw the deceased alive on Oct. 27, 1966, and that death occurred at 7:50 AM, from the causes and on the date stated above.

22e. SIGNATURE

Bernard C. Thomas Jr. M.D.

22b. DATE SIGNED

11/3/66

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

Professional Building, Frederick, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial 11/4/66

23b. DATE THEREOF

11/4/66

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Hope

ADDRESS

ADDRESS

G. C. Barton, Walkersville, Md.

23d. LOCATION (City/town or county)

Woodsboro

(State)

md.

25a. REC'D BY REGISTRAR

NOV 1 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

DATE

NOV 1 1966



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15630

CERTIFICATE OF DEATH

15633

TO HOSPITAL
death. Page 4
TO FUNERAL
DIRECTOR: After this certificate has
been signed by the attending physician,
page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

FREDERICK

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

JOHNSVILLE

c. LENGTH OF STAY IN TB

MARYLAND

YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

UNION BRIDGE RURAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
Month Day Year

NOV. 27 1966

5. SEX

F W

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

AUG 16-1899 67

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE AT HOME

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

EDWARD F. CRAWMER

14. MOTHER'S MAIDEN NAME

AMELIA STEINBERG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give rank and dates of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

1805-10-4907 SAMUEL E. FOGLE, JOHNSVILLE MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

congestive myocardial failure

Arteriosclerotic cardiovascular disease

Hypertensive cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH

6 weeks

10 year

15 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY

PERFORMED?

YES NO

Rheumatoid arthritis severe

20e. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18)

20c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

21. I certify that (I) (this hospital) attended the deceased from August 1966 to Nov. 1966, that (I) (we) last saw the deceased alive on Nov. 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22e. SIGNATURE

James E. Stoner

22c. PHYSICIAN'S

NAME (Type)

JAMES E. STONE, M.D.

M.D.

ATTENDING

PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

11/28/66

23a. BURIAL, CREMATION, REMOVAL (Spec.)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

DATE DEC 1 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

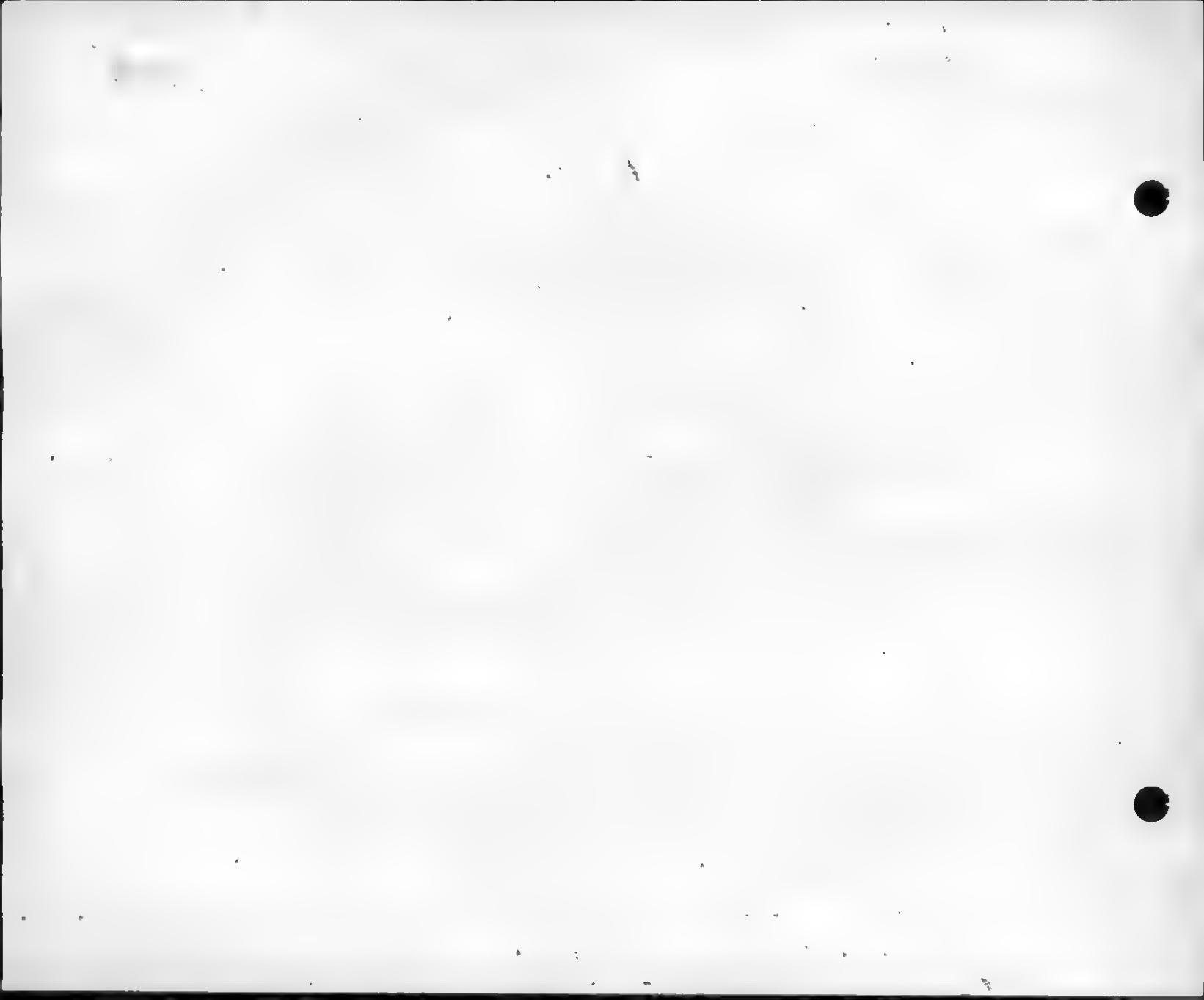
15631

CERTIFICATE OF DEATH

15634

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/trans.t permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN lb 15 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) Guy Troxell Frushour		First Middle Last	4 DATE OF DEATH Nov. 7 1966
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 DATE OF BIRTH Apr. 24, 1889
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Accountant		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysses Grant Frushour		14. MOTHER'S MAIDEN NAME Catherine Main	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) Yes WWI		16. SOCIAL SECURITY NO 213-34-2287	17. INFORMANT Miss Mary Frushour Address Graceham, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Posterior Hemmorrhage</i> - DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 to <u>Nov</u> , 1966 that (I) (we) last saw the deceased alive on <u>11/5/66</u> , and that death occurred at <u>98M</u> , fram causes and on the date stated above		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Thomas A. Love</i>		22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Thomas A. Love	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-66	23c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR DATE NOV 10 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15632

CERTIFICATE OF DEATH

15635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 hour		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Jefferson		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie		First	Middle	Last	4. DATE OF DEATH Novembe	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17- 1883		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homenaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Emanuel Hine		14. MOTHER'S MAIDEN NAME Mary Catherine Green							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 212-38-9990		17. INFORMANT Mrs. Effie A. Roderuck- Jefferson, Md. 21755		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		b) <i>acute decompensation from coronary disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days			
		DUE TO (b) <i>decompensated coronary disease</i>							
		c) <i>decompensated coronary disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Genuinely						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on.....		to..... and that death occurred at.....		22b. DATE SIGNED Nov. 18-66					
22c. SIGNATURE <i>Dr. Talbot Brice, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Dr. A. Talbot Brice		22d. ADDRESS Jefferson, Maryland 21755							
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION (City, town or county) Jefferson, Md. 21755					
24 FUNERAL DIRECTOR'S SIGNATURE <i>Elwood T. Whitmore</i> B.R. Hitchison & Son		ADDRESS <i>Frederick, Md. 21701</i>		25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 22 1966 <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15633

15636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove the seal and file with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

Frederick

MARYLAND

c. LENGTH OF STAY IN 16

Years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

304 Rockwell Terrace

3. NAME OF
DECEASED
(Type or print)

First

Middle

Virginia

Lane

Gambrill

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 12, 1897

9. AGE (In years
last birthday)

69

yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Months

Days

11. KIND OF BUSINESS OR INDUSTRY

Hours

Min.

10a. BIRTHPLACE (County & State, or foreign country)

Housewife

11. BIRTHPLACE (County & State, or foreign country)

Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Preston Lane, Sr.

Virginia Cartwright

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

213 48 8005

James H. Gambrill, III

(Same as item # 2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Heart Disease Thrombosis

Arteriosclerotic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

6 weeks

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20c. TIME OF INJURY

Hour a.m.

p.m.

20d. INJURY OCCURRED

White

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Not White

at work

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 3, 1966, to Nov. 16, 1966, that (I) (we) last saw the deceased alive on Nov. 15, 1966, and that death occurred at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE

A. Austin Pearre, Sr. M.D.

22b. DATE
SIGNEDATTENDING PHYS. MED. DIRECTOR STAFF PHYS. November 16, 1966

22c. PHYSICIAN'S NAME (Type)

A. Austin Pearre, Sr. M.D.

22d. ADDRESS

4 E. Church Street, Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 18, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Donald W. Addley

ADDRESS

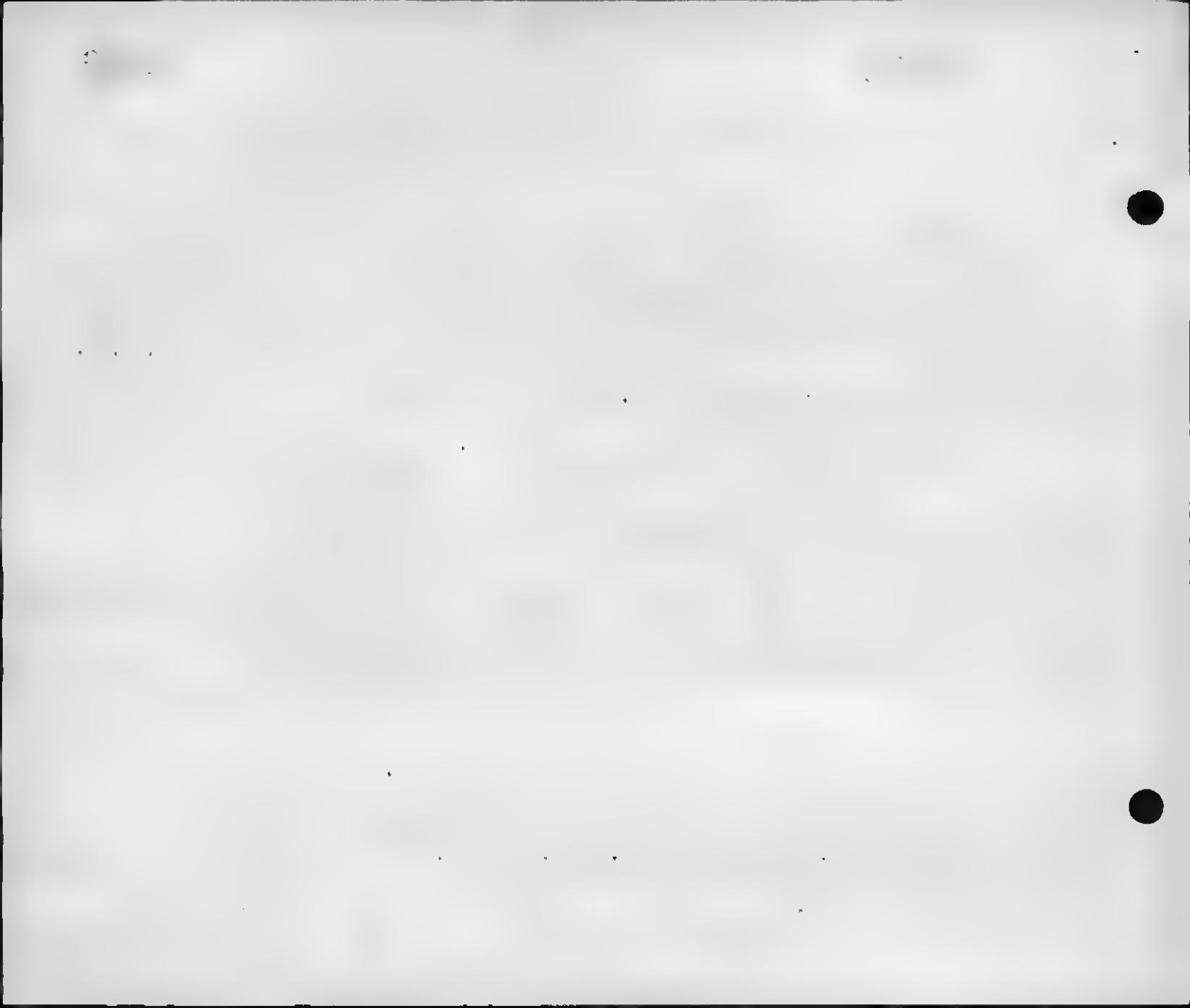
101 W. Litchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

Charles Judge

25b. REGISTRAR'S SIGNATURE

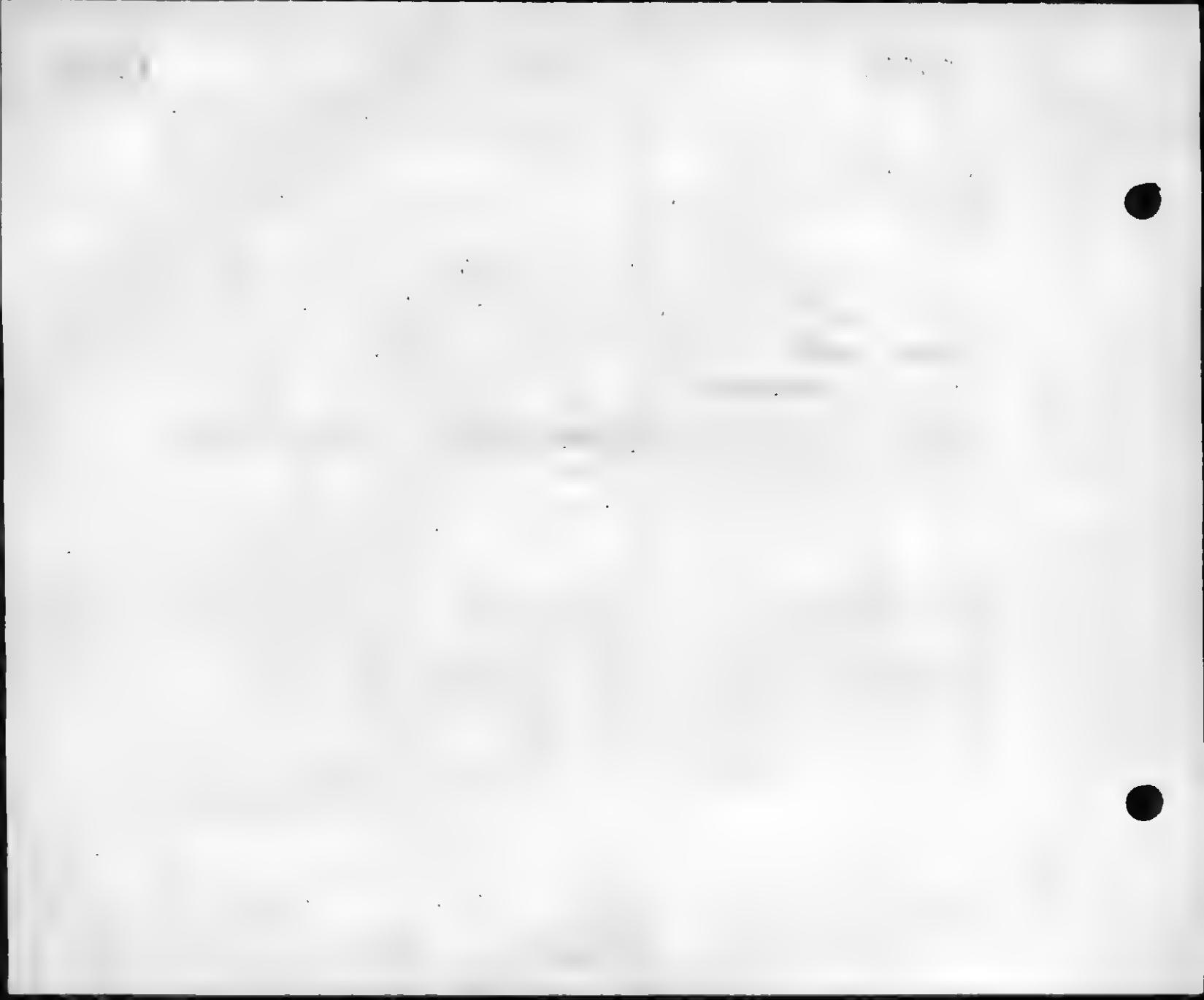
NOV 18 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. If you require removal of the body, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THURMONT R.D. 1 c. LENGTH OF STAY IN 1b THURMONT R.D. 1 MD.				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD. b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THURMONT R.D. 1 MD.								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) THURMONT R.D. 1 MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First IDA	Middle E.	Last GRAYBILL	4. DATE OF DEATH	Month 11	Day 18	Year 1966				
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1878	9. AGE (in years last birthday) 88 yrs.	10. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	11. BIRTHPLACE (County & State, or foreign country) YORK CO. PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME ISRAEL BAUBLITZ			
14. MOTHER'S MAIDEN NAME JOSEPHINE ZINN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 162-32-2681	17. INFORMANT AUSTIN G. CORWELL	Address YORK R.D. 1 PA.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Dover	(County) Twp.	(State) PA.				
21. I certify that (I) (this hospital) attended the deceased from Nov 18 , 1966, to Nov 18 , 1966, that (I) (we) last saw the deceased alive on Nov 18 , 1966, and that death occurred at M. from the causes and on the date stated above.												
22a. SIGNATURE Thomas E. Stone				22b. DATE SIGNED 11-19-66								
22c. PHYSICIAN'S NAME (Type) Thomas STONE				22d. ADDRESS Frederick, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11-22-1966	23c. NAME OF CEMETERY OR CREMATORIAL UNION SALEM UNION	23d. LOCATION (City, town or county) DOVER TWP PA.	(State)					
24. FUNERAL DIRECTOR Henry K. Sodeau Jr.				ADDRESS York, Pa.	25a. REC'D BY REGISTRAR NOV 25 1966	25b. DATE NOV 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that his death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

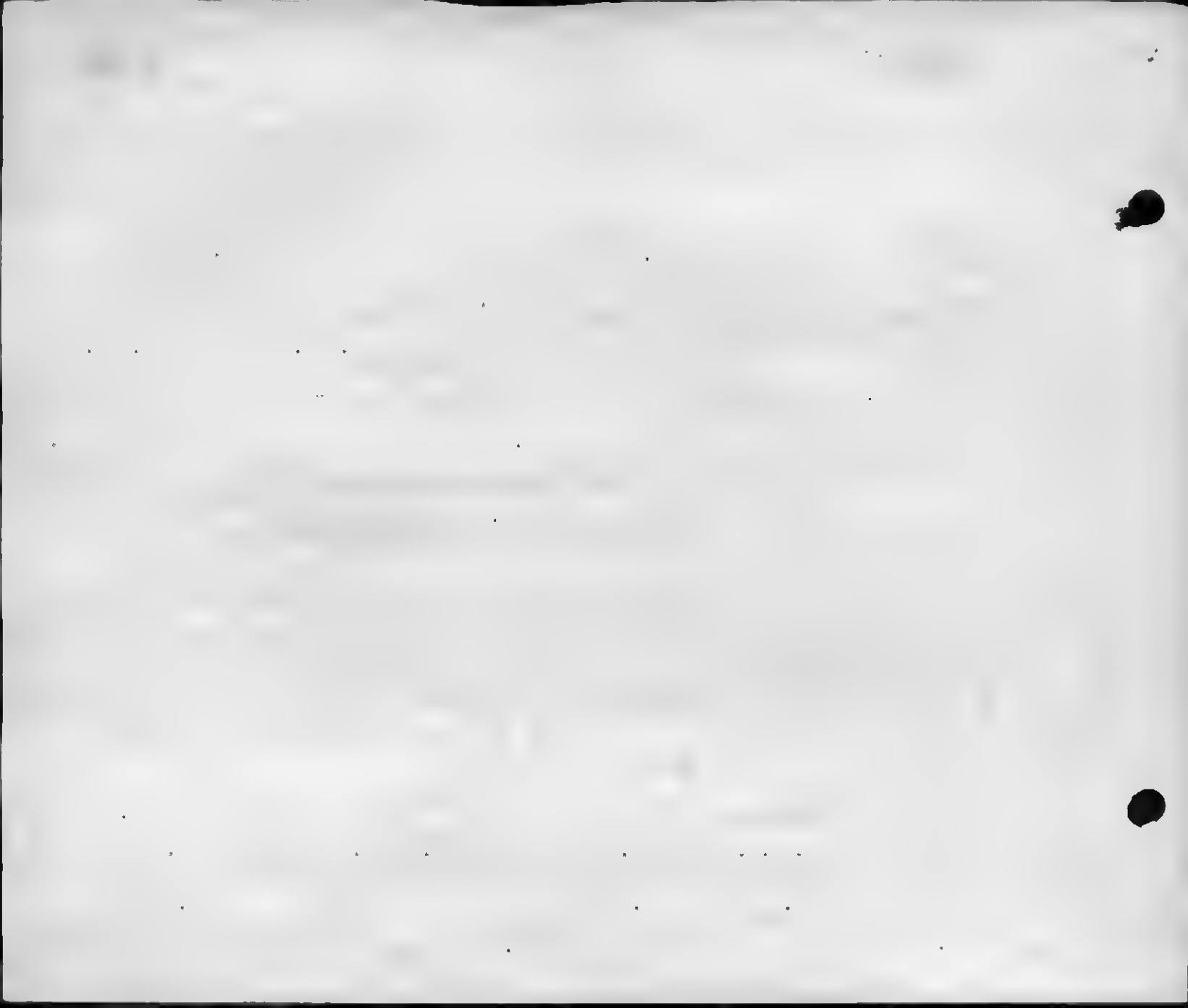
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15635

15638

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN 16 Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn R. White Grove		4. DATE OF DEATH Nov. 12-1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 14-1910	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Dance Studio	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. White - deceased		14. MOTHER'S MAIDEN NAME Rosalie Lingg - living	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT 493-24-5250 Mr. Robert K. Grove - Route 5-Frederick, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 month	
DUE TO (b) DUE TO (c)		Adeno-carcinoma (right breast) 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 25, 1966 to Nov. 12, 1966, that (I) (we) last saw the deceased alive on Nov. 12, 1966, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE B.O. Thomas Jr.		22b. DATE SIGNED Nov. 12-66	
22c. PHYSICIAN'S NAME (Type) Dr. B.O.Thomas-Jr.		22d. ADDRESS Prof. Bldg. - Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17-1966	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701	
24. FUNERAL DIRECTOR'S SIGNATURE M.R.Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701	
25a. REC'D BY REGISTRAR NOV 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

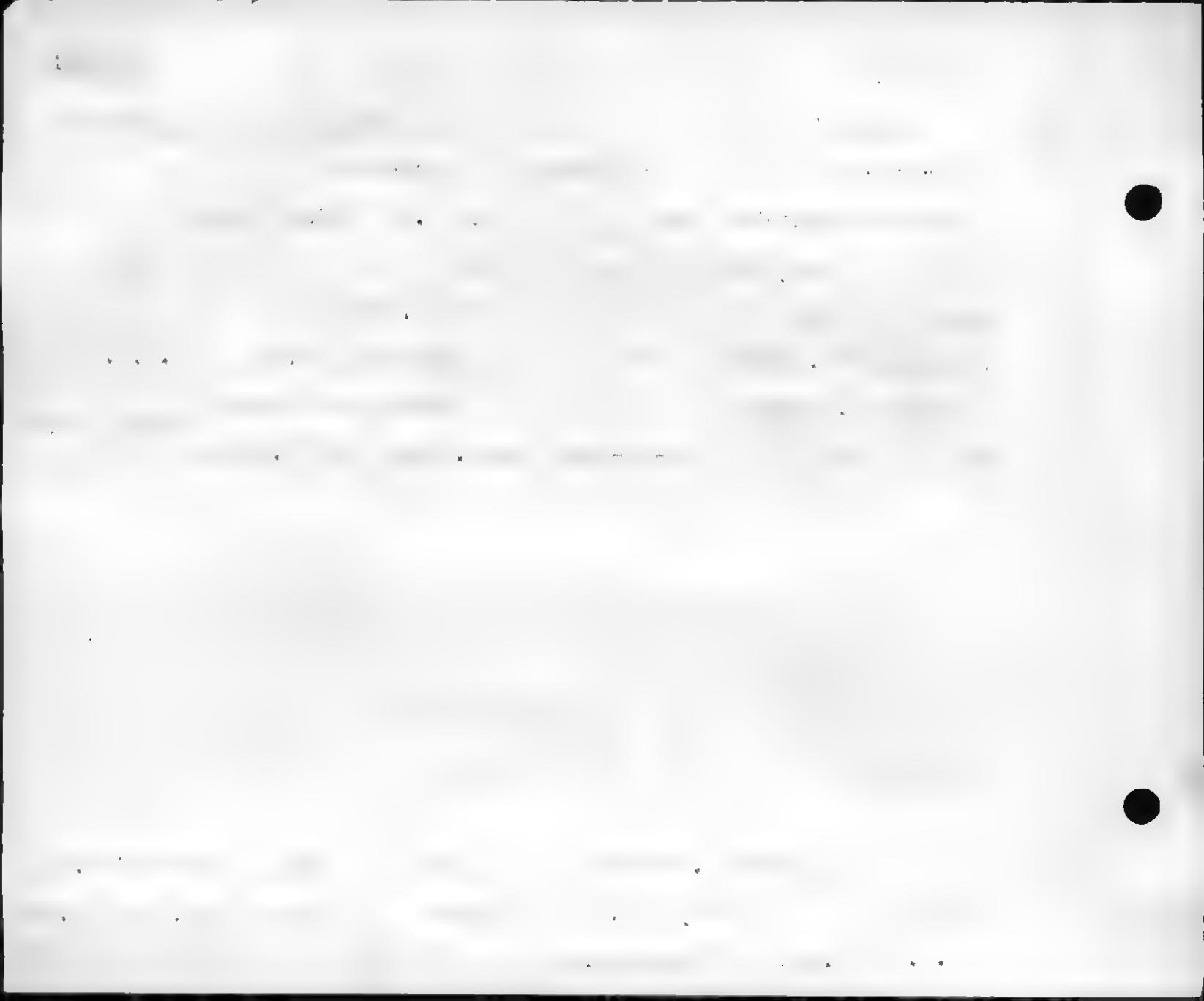
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15636

CERTIFICATE OF DEATH

15639

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate lim.ts, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 13 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 23 W. All Saints Street		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sylvester Ambrose Gwynn		First	Middle	Last	4. DATE OF DEATH Month Nov 14 1966	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27, 1906	9. AGE (in years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Passenger Ft. Detrick		10b. KIND OF BUSINESS OR INDUSTRY ***		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George R. Gwynn		14. MOTHER'S MAIDEN NAME Cornelia Fletcher		Address Frederick, Md				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 219-14-9422		17. INFORMANT Ida N. Gwynn				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Congestive Heart Failure						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Bronchopneumonia					
		DUE TO (c)	Etiologic Agent to be determined					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Chronic Rheumatic Heart Disease						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 804 Toll House Ave Frederick, Md		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1966 , to Nov. 14, 1966 , that (I) (we) last saw the deceased alive on Nov. 13, 1966 , and that death occurred at 6:25 AM , from the causes and on the date stated above.		22b. DATE SIGNED 11/14/66						
22a. SIGNATURE Richard C. Reynolds		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave Frederick, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/66		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Church		23d. LOCATION (City, town or county) (State) Petersville, Fred Co., Md		
24. FUNERAL DIRECTOR C.E. Hicks, III		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge						
ADDRESS Frederick, Md		DATE NOV 16 1966						



FOR STATE
HEALTH DEPT.

Necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

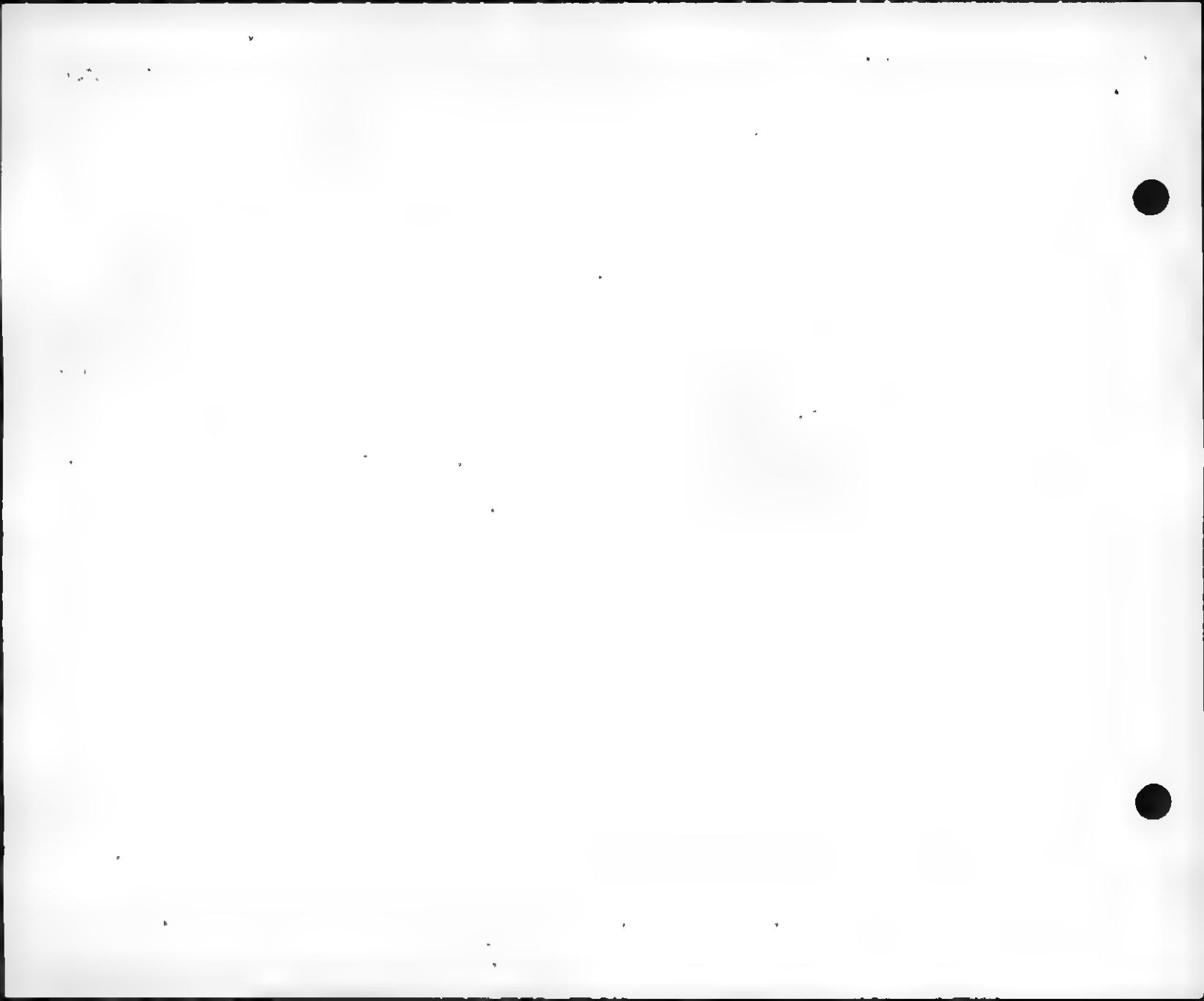
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15640

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write R.RAL and give nearest town) Rural - Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 6			d. STREET ADDRESS Route 6			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mabel		First T.	Middle Hargett	4. DATE OF DEATH November 10- 19 66	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4- 1914	9. AGE (In years last birthday) 52 yrs	F. UNDER 1 YEAR Months	F. UNDER 24 HRS Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert S. Morgan			14. MOTHER'S MAIDEN NAME Katie Jones						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		6. SOCIAL SECURITY NO None		17. INFORMANT Hugh D. Hargett- Route 6- Frederick, Md. 21701		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of L. breast with								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO stating the underlying cause lost. (c)		Metastasis to lung					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS A TROPSE PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE B. Thomas		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						22. DATE SIGNED Nov. 11-1966	
23a. BURIAL, CREMATION, REMOVAL (Spec'd) Burial		23b. DATE THEREOF Nov. 14-1966		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Md. 21701		(County)	(State)
24. FUNERAL DIRECTOR Elwood T. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR NOV 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME (5) 6M 1/66									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15638

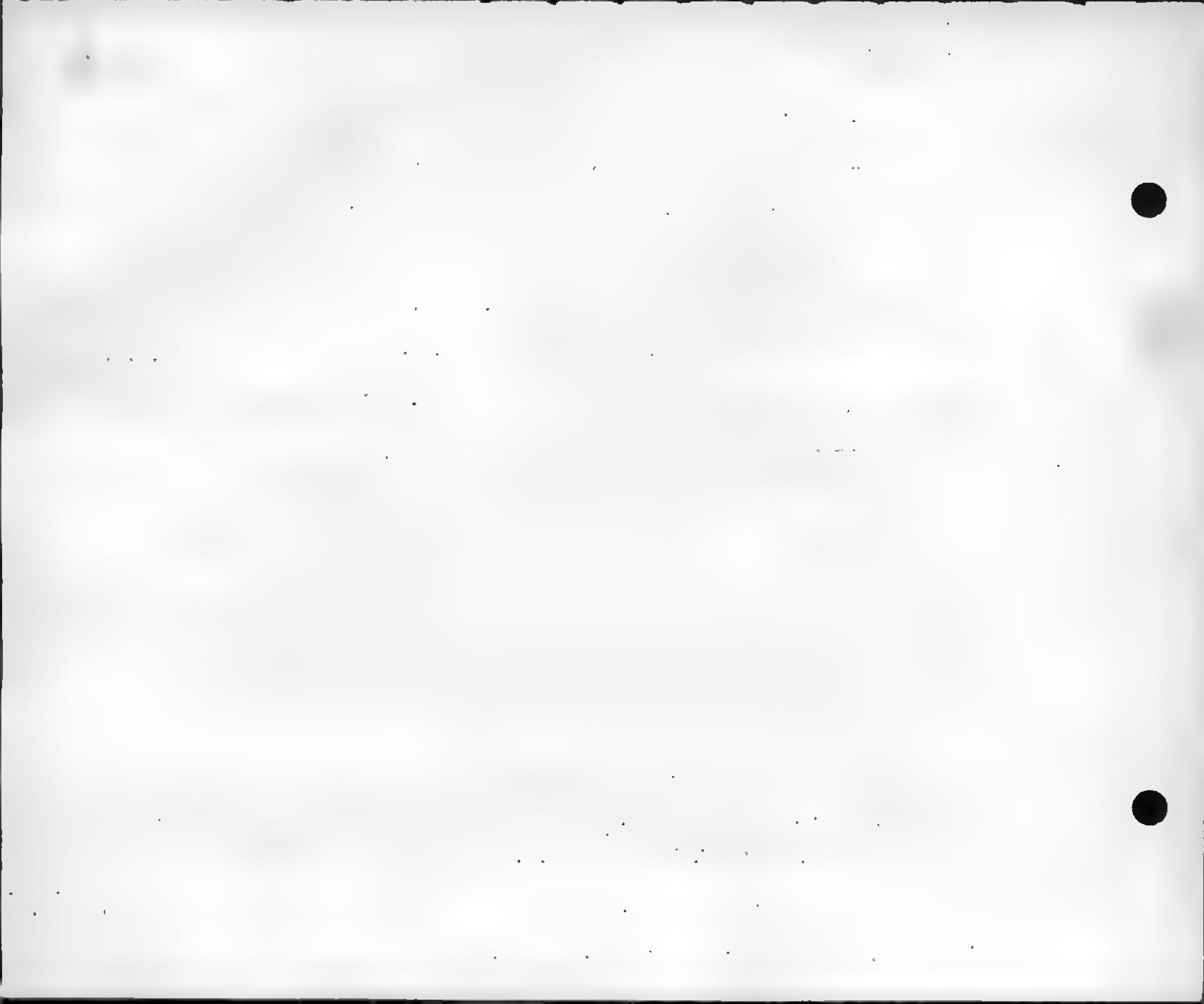
CERTIFICATE OF DEATH

15641

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit form. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

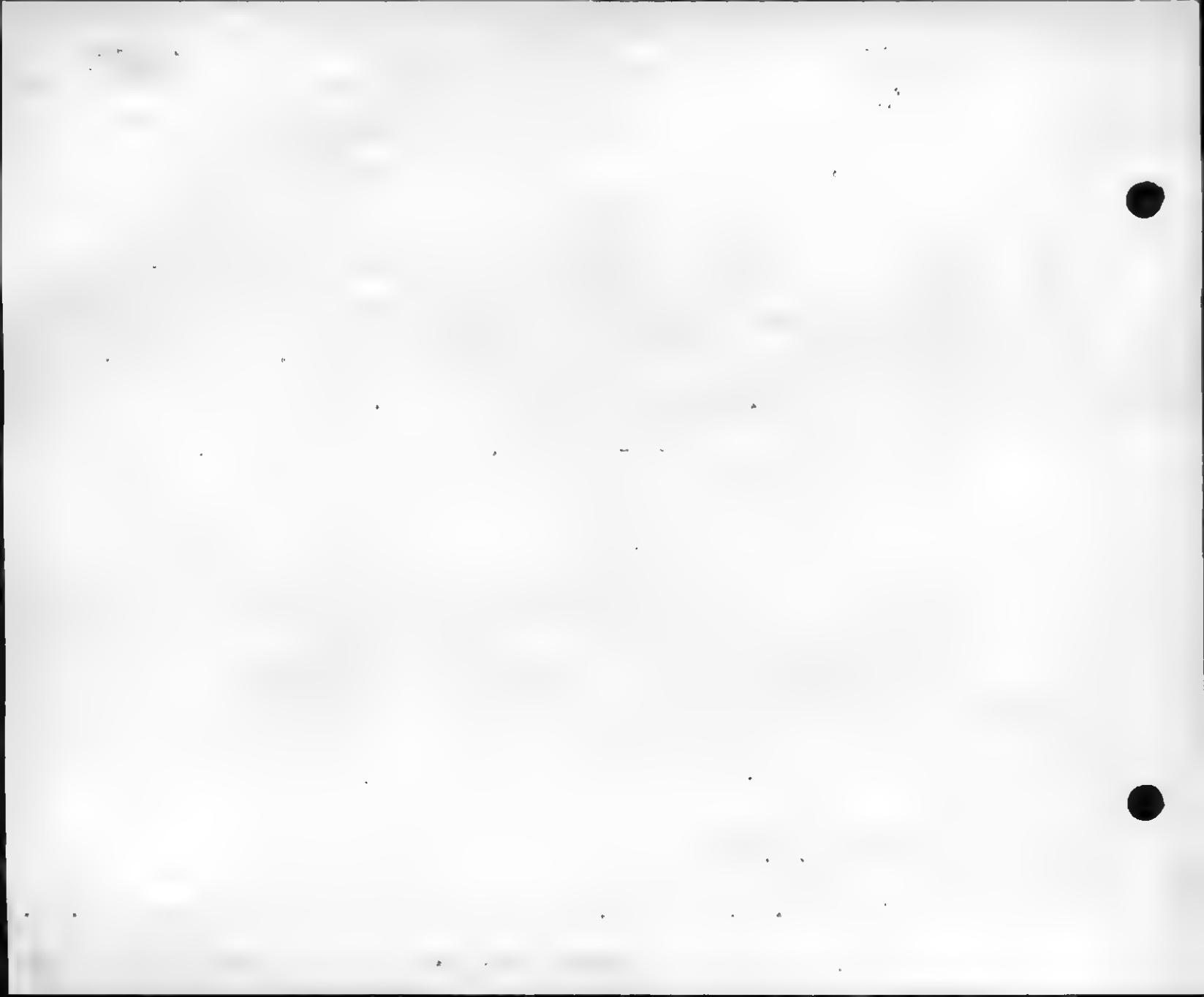
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS Route XXX # 4	
3. NAME OF DECEASED (Type or print)	First MARY	Middle KATHRYN	Last HEINE
4. DATE OF DEATH November 29 1966	Month NOV	Day 29	Year 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH November 29, 1966	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Joseph Heine		14. MOTHER'S MAIDEN NAME Mary Kathryn Wilder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
vrespiratory center failure immaturity 21 wks preancy			
INTERVAL BETWEEN ONSET AND DEATH in 15m			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Frederick		(County) (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 11/29/66 to 11/29/66 , that (I) (we) last saw the deceased alive on 11/29/66 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Harry W. Gray			
22b. DATE SIGNED 11/30/66			
22c. PHYSICIAN'S NAME (Type) Dr. Harry W. Gray		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS Frederick, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-30-1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Josephs Catholic Cemetery
23d. LOCATION (City, town or county) Carrollton Manor		(State) Fred. Co. Md.	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRATION DEC 1 1966
			25b. REGISTRAR'S SIGNATURE John J. Murphy



HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
15639 CERTIFICATE OF DEATH 15642															
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE									
Frederick MARYLAND						Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			b. COUNTY			Frederick						
Emmitsburg,			59 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS									
West Main						West Main									
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year				
Female			Mary	Alice	Higbee	November 19,			19	66					
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (in years) <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS.					
Female		White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		April 22, 1881		85	Yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife								Somerville, Mass.				U.S.A.			
13. FATHER'S NAME															
Frederick M. Kilmer															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			216-54-8640			Mrs. Harold Hoke, Emmitsburg, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion -</i> INTERVAL BETWEEN ONSET AND DEATH 1 hour															
42 i Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteries arteriosclerotic disease - several years</i>															
(c) <i>Hypertension - - several years</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
19															
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1940</i> , to <i>Nov 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 15 1966</i> , and that death occurred at <i>Emmitsburg</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>W.R. Cadle</i>															
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED									
W. R. Cadle			Emmitsburg, Maryland			11-20-66									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			Nov. 22, 1966			Mt. View Cemetery			Emmitsburg, Frederick Co. Md.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Clarence E. Wilson			Emmitsburg, Md.			NOV 22 1966			j Charles Judge						
Clarence E. Wilson															



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

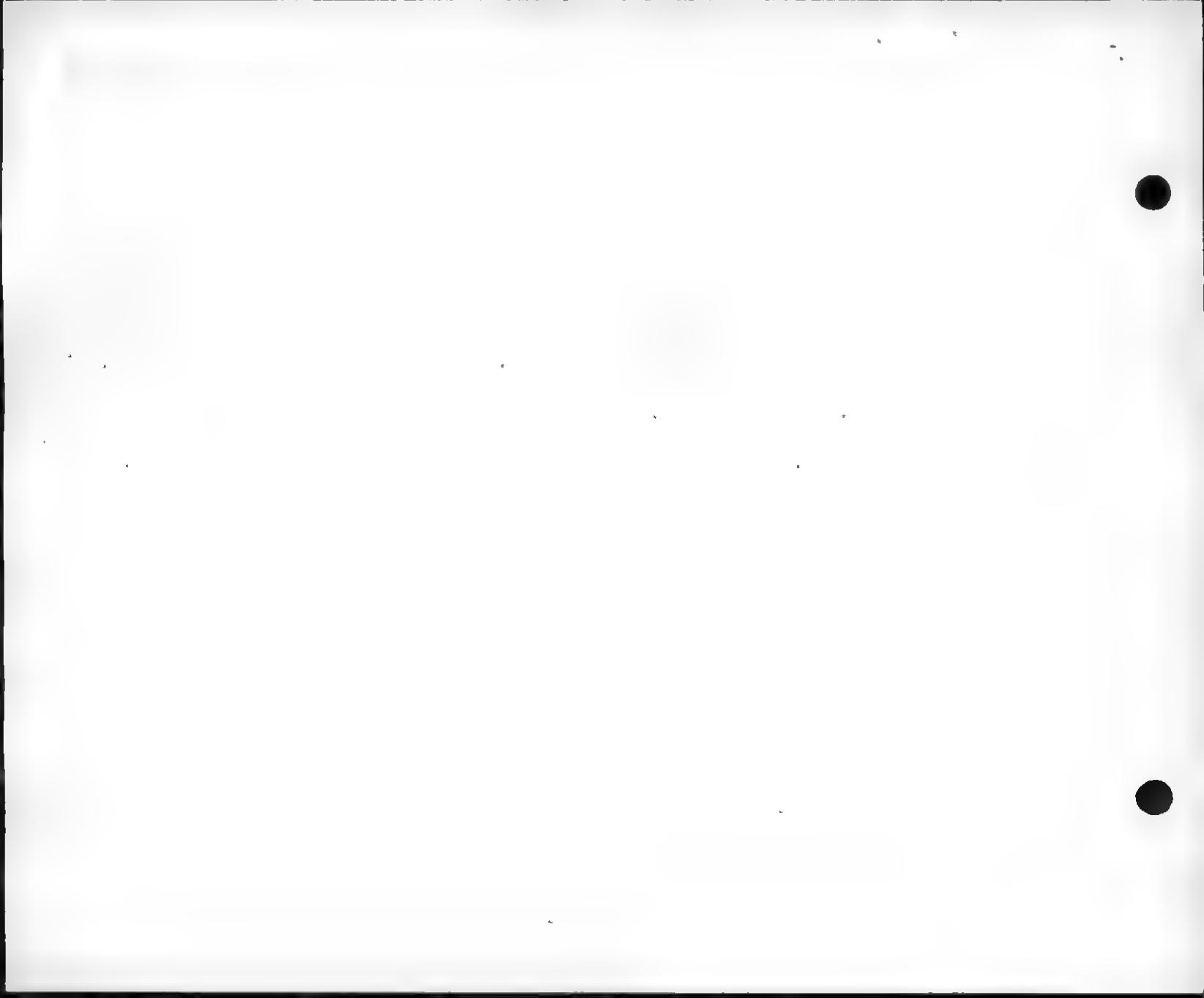
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15643

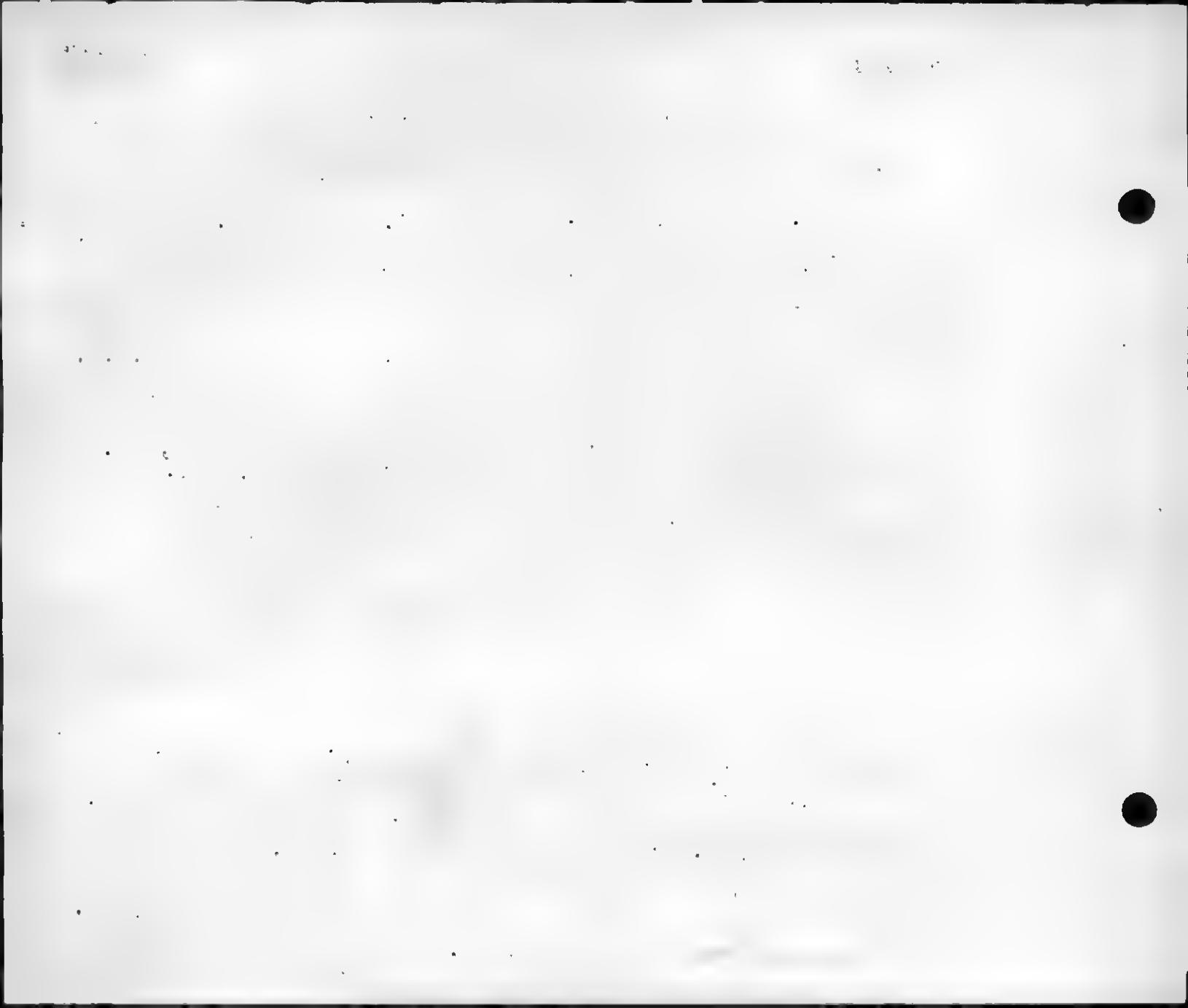
1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 605 North Market Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 605 North Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NATHAN		First OWEN	Middle HOLLENBAUGH, JR.	4. DATE OF DEATH Month November	Month 20	Doy 1966	Year
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH July 12, 1909	9 AGE (in years last birthday) 57 yrs	F UNDER 1 YEAR Months 57	F UNDER 24 HRS Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY Meadow Storage Co.		11 BIRTHPLACE (State or foreign country) Barkhill, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Nathan O. Hollenbaugh, Jr.		14 MOTHER'S MAIDEN NAME Lillian Keefer					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service Yes W. W. # 2		16 SOCIAL SECURITY NO 220 07 7614		17 INFORMANT		Address Roger Hollenbaugh, 180 Longview Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarct 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost (b) Emphysema DUE TO (c) Arteriosclerotic heart disease DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20c EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Nov. 21, 1966	
ACTUAL SIGNATURE B. O. Thomas, Sr. M. D.		EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 23, 1966		23c NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Frederick, Maryland	
24 FUNERAL DIRECTOR Donald M. Etchison & Son, Frederick, Maryland		ADDRESS Fadeley		25a REC'D BY REG STRR DATE NOV 22 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
15641					15641				
1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick 5 weeks			a. STATE Maryland		b. COUNTY Frederick		
c. LENGTH OF STAY IN 1D					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Frederick Co. Emergency Hosp.			Brunswick				
e. IS RESIDENCE ON A FARM?					d. STREET ADDRESS				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					401 W. Potomac St.				
3. NAME OF DECEASED (Type or print)		First Maurice	Middle Lawson	Last House	4. DATE OF DEATH	Month Nov	Day 5	Year 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR Months 86 yrs.	IF UNDER 24 HRS Days Hours Min.		
Male		White		9/26/80	86 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Brakeman			Railroad			Maryland			U.S.A.
13. FATHER'S NAME									
Lawson House									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		Unknown		Shannon Langley-Brunswick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Arteriosclerotic cardiovascular INTERVAL BETWEEN ONSET AND DEATH 34 hrs.									
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arterosclerotic cardiovascular (c) 10 years,									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
19									
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1966 to Oct 3, 1966, that (I) (we) last saw the deceased alive on Oct 5, 1966, and that death occurred at 1 P.M. from the causes and on the date stated above.									
22a. SIGNATURE LeRoy T. Davis 22b. DATE SIGNED 11/7/66									
22c. PHYSICIAN'S NAME (Type)		LeRoy T. Davis		22d. ADDRESS		Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)			
Burial		11/8/66		Union Cemetery		Lovettsville, Va.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tate Funeral Home				DATE NOV 9 1966		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15642

CERTIFICATE OF DEATH

15645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certifcate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

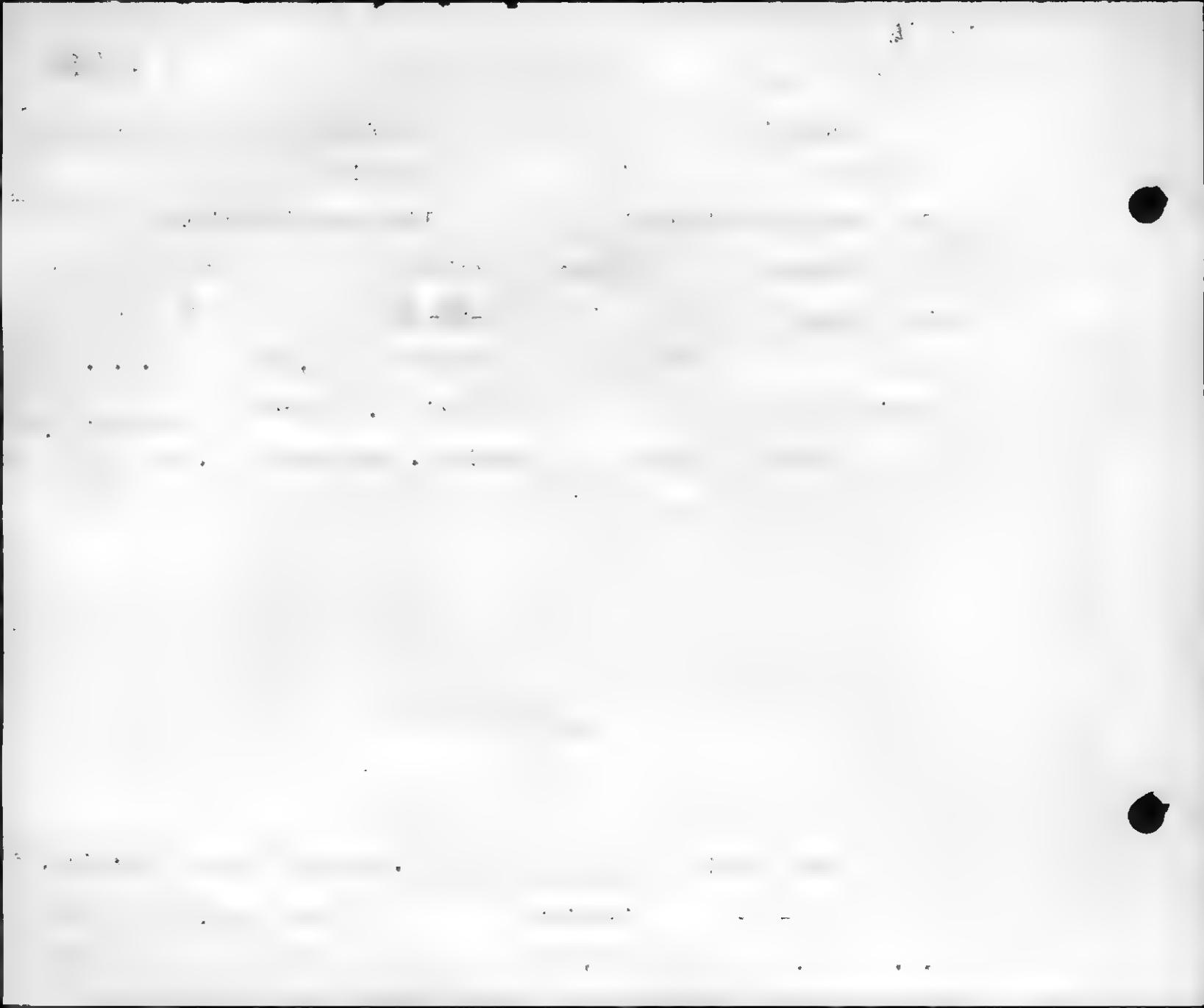
1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE HENRY HUFFMAN		First G	Middle H
4. DATE OF DEATH NOV 17 1966		Last N	Month NOV
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 31, 1906		9. AGE (In years last birthday) IF UNDER 1 YEAR 60 yrs. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W HUFFMAN		14. MOTHER'S MAIDEN NAME ETTA EYLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service NO		16. SOCIAL SECURITY NO. 220-34-2285	
17. INFORMANT MILDRED HUFFMAN		Address WALKERSVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 12 days 10 years	
Cerebral hemorrhage Cerebral thrombosis = left hemiplegia & dysarthria Atherosclerotic & hypertensive CVD			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old cerebrovascular accident & residual right hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1b or Part II if item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6 1949 to 11/17 1966, that (I) (we) last saw the deceased alive on 11/16 1966, and that death occurred at 1:45 AM, from the causes and on the date stated above		22b. DATE SIGNED 11/17/66	
22a. SIGNATURE James E. Stoner, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) JAMES E. STONER, JR		22d. ADDRESS WALKERSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/19/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS MT HOPE
24. FUNERAL DIRECTOR'S SIGNATURE Lowell Hartzler Woodsboro, Md		25a. REGISTRATION DATE NOV 21 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		15646							
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					b. COUNTY									
Frederick MARYLAND					Maryland					Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					d. STREET ADDRESS									
Frederick Life					Frederick					167 West All Saints St									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM?														
167 West All Saints St					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year					
Derrick		Anthony		Jackson				Nov 20 1966											
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		Negro		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9-26-1966		yrs. 1 24		Months		Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
None					*****					Frederick Co., Md					U.S.A.				
13. FATHER'S NAME																			
Jessie White																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT					Address				
No *****					None					Doris E. Jackson					Frederick, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza																			
DUE TO																			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.					(b)					(c)					INTERVAL BETWEEN DINSET AND DEATH 7 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11-18-1966 to 11-20-1966, that (I) (we) last saw the deceased alive on 11-18-1966, and that death occurred at 7 A.M. from the causes and on the date stated above.															22b. DATE SIGNED				
22a. SIGNATURE <i>Rex Martin</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS					22c. PHYSICIAN'S NAME (Type)				
Rex Martin										220 N. Market Street Frederick, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-21-66					23c. NAME OF CEMETERY OR CREMATORIUM Fairview					23d. LOCATION (City, town or county) (State) Frederick Co, Md				
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md					ADDRESS					25a. REC'D BY REGISTRAR NOV 23 1966					25d. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 1/65																			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15644

CERTIFICATE OF DEATH

Reg. Dist. No.

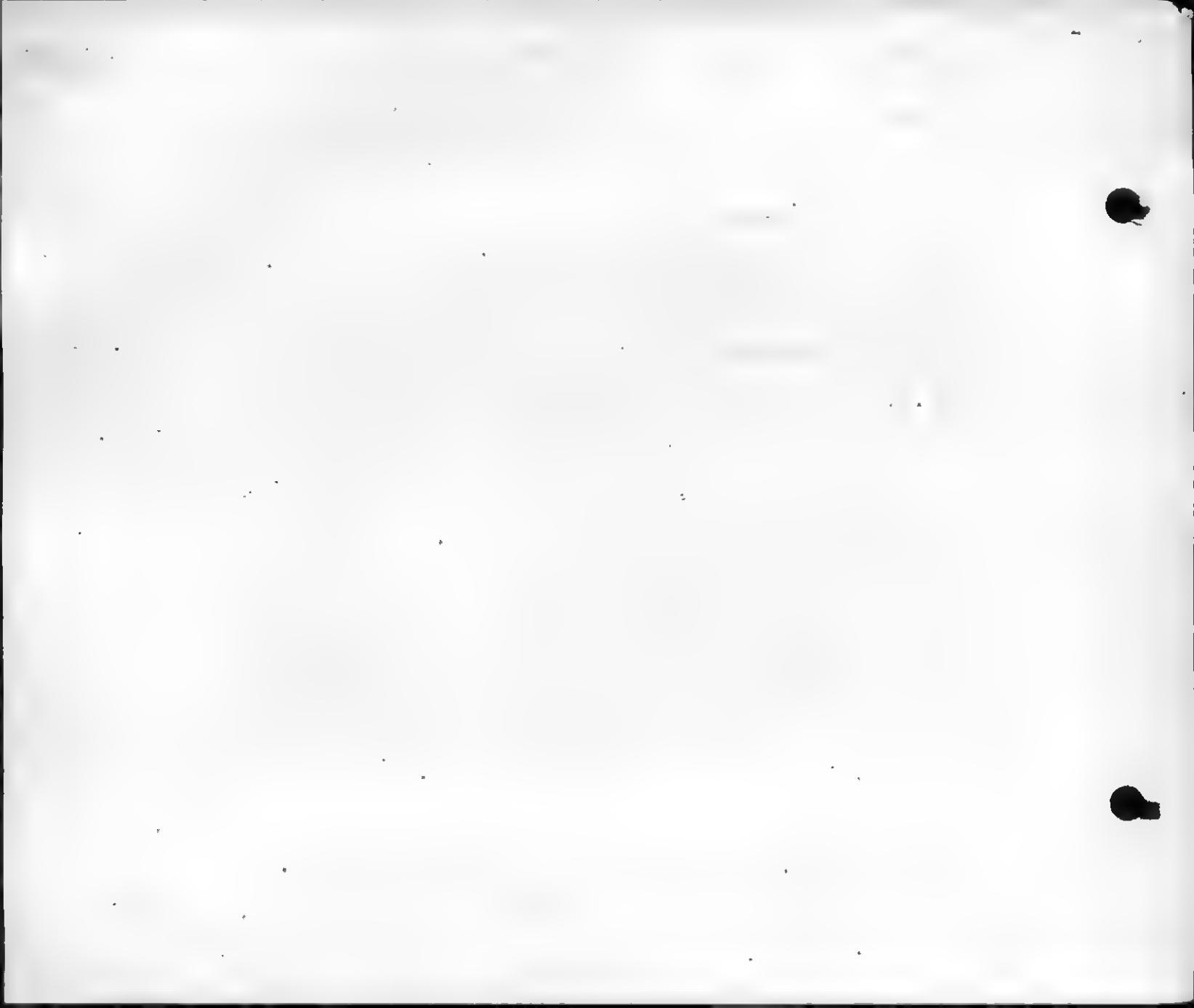
15647

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Ijamsville		c. LENGTH OF STAY IN lb 9 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 7914 Radnor Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle Whiteside	Last Kirk	4. DATE OF DEATH Nov. 18 1966	Month	Day	Year
S. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct 8 1892	9 AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS Days 18	Hours 00
10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Shovel Operator -Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert		14. MOTHER'S MAIDEN NAME Frances Wexx Little					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. 098-01-4026		INFORMANT Wife Eva Kirk		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis and Arteriosclerotic DUE TO Heart Disease. INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
Conditions of any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour o. m. p. m.		Month Feb	Day 25	Year 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 25 1966 to Nov 18 1966 that I last saw the deceased alive on Nov 18 1966 , and that death occurred at 7:15 AM , from the causes and on the date stated above p. ADDRESS (Street, city or town, state) DATE SIGNED Nov 18 66							
ACTUAL SIGNATURE Joseph Lerner							
PHYSICIAN'S NAME (Type) Joseph Lerner							
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland							
ADDRESS				24a. REC'D BY REGISTRAR NOV 23 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR HOSPITAL DIRECTOR: This physician certifies that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

■ F NERL D TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

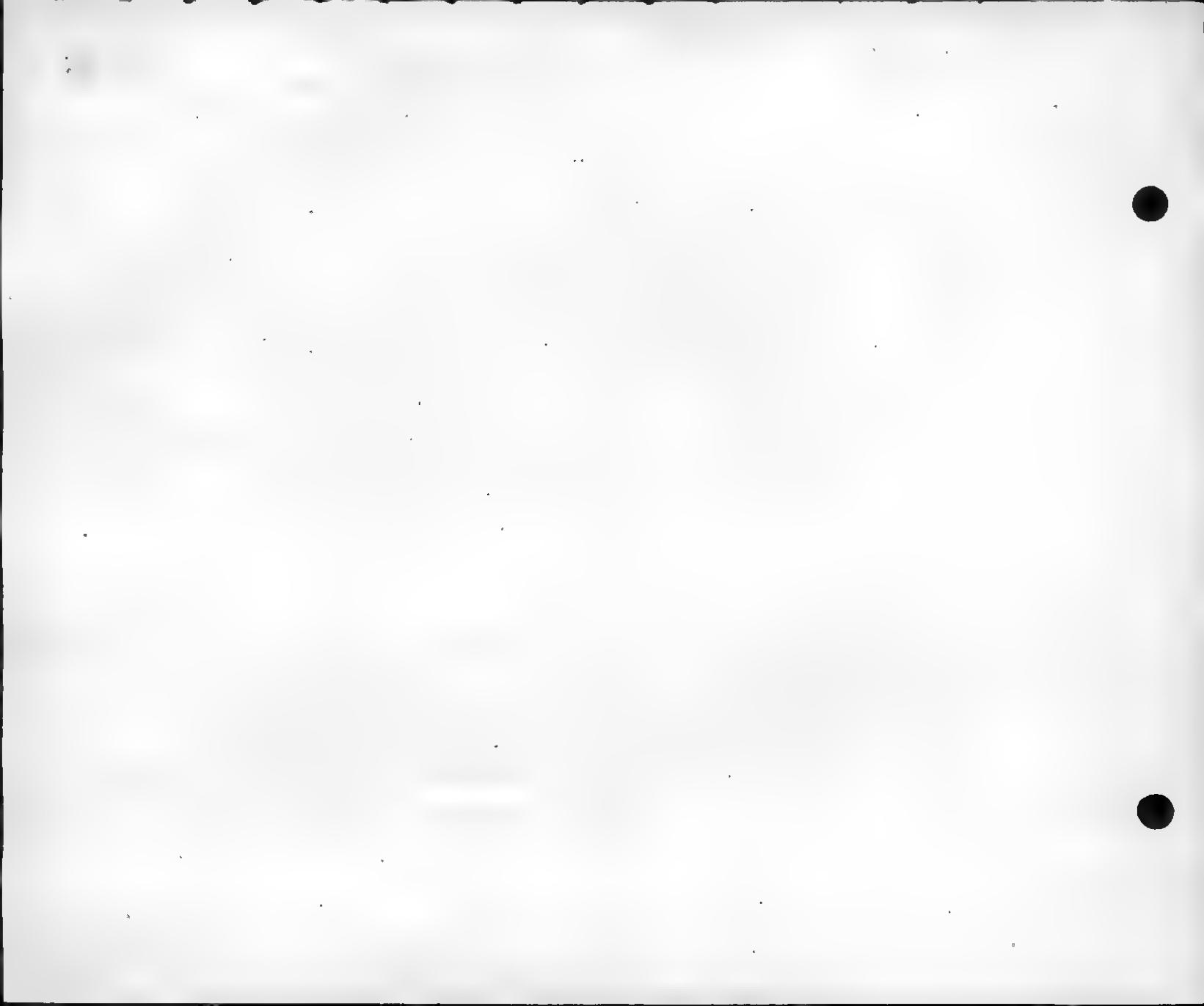
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15645

CERTIFICATE OF DEATH

15648

1. PLACE OF DEATH b. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 week				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Edgar	Middle Harrison	Last Koogle			
4. DATE OF DEATH Month Nov	Day 2	Year 1966				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1888			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper, ret. retail grocery	10b. BUSINESS OR INDUSTRY Industry	11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Sherman Koogle	14. MOTHER'S MAIDEN NAME Fannie Smith	Address 200 E. 4th				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Laura Gaver, Frederick, Md.				
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of brain						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis						
DUE TO (c) Generalized arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 804 Toll House Ave	20f. (City or town) Middletown	(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 10/24 , 19 66 , to 11/2 , 19 66 , that (I) (we) last saw the deceased alive on Nov 2 19 66 , and that death occurred at 10⁴⁵ M, from the causes and on the date stated above.						
22a. SIGNATURE Henry V. Chase				22b. DATE SIGNED 2 Nov 66		
22c. PHYSICIAN'S NAME (Type) Henry V. Chase				22d. ADDRESS 804 Toll House Ave Frederick Md		
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) burial	23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	23d. LOCATION (City, town or county) Middletown	(State) Md.		
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE			
DATE NOV 4 1966						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

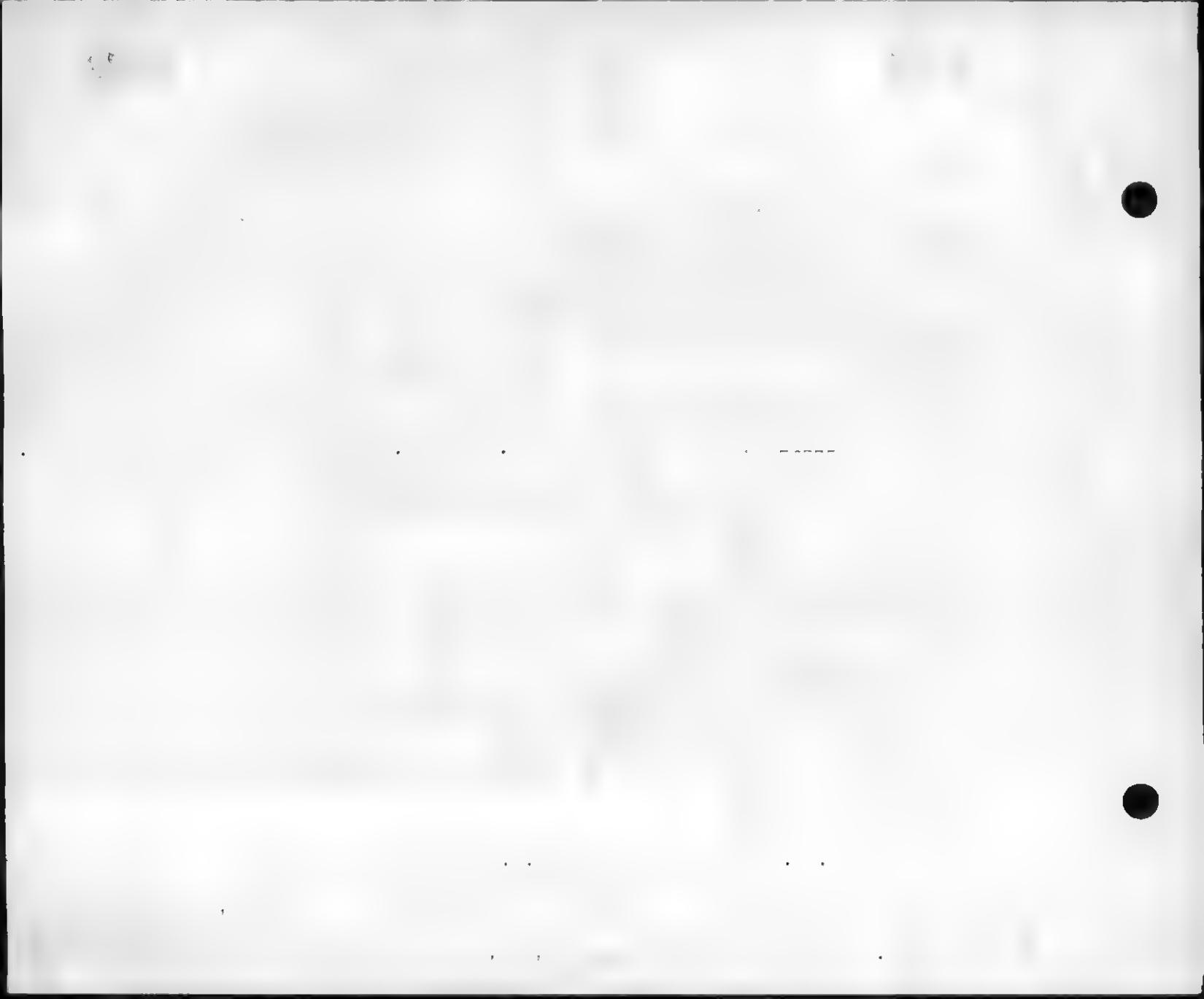
15649

certificate by executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

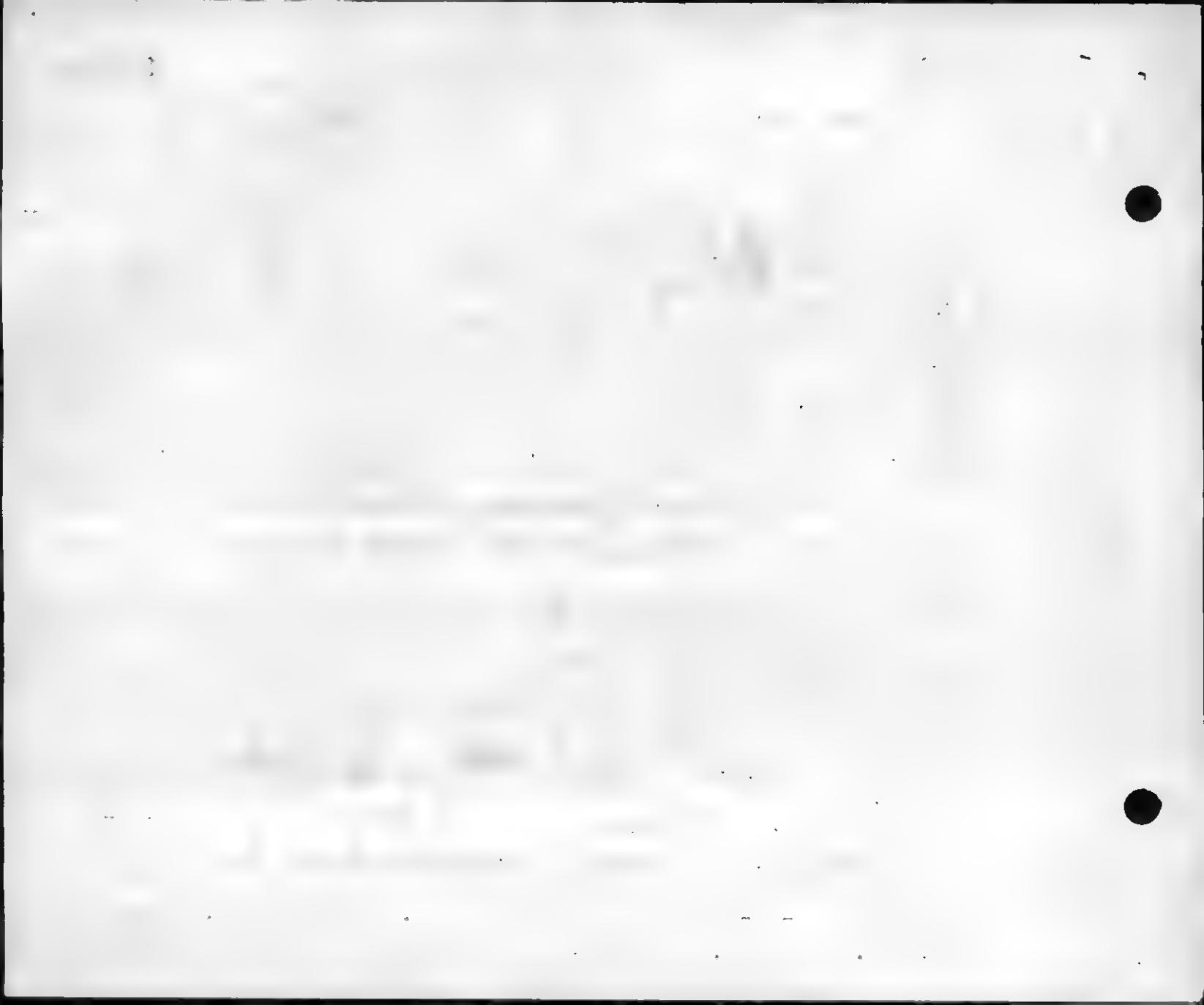
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
FREDERICK MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick	
R.FREDERICK		c. LENGTH OF STAY IN b. hours	
d. NAMES OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RURAL #1 Middletown	
Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KANDY KAY LAKE		4. DATE OF DEATH Nov. 2 1966	
5. SEX F 6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/5/66		9. AGE (in years last birthday) yrs. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MR. Henry Lawrence LAKE		14. MOTHER'S MAIDEN NAME Fahnestock, Carolyn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Henry L. Lake Route #1, Middletown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE SEPTICEMIA			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MENINGOCOCCEMIA, ACUTE			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 1 1966 , to NOV 2 1966 that (I) (we) last saw the deceased alive on NOV 2 1966 , and that death occurred at 1:00 AM , from the causes and on the date stated above			
22a. SIGNATURE <i>J. Fred Baker</i>		22b. DATE SIGNED 11-2-66	
22c. PHYSICIAN'S NAME (Type) Dr. J. Fred Baker		22d. ADDRESS Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Darley & Son		25a. REC'D BY REGISTRAR NOV 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE							
Frederick				Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				b. COUNTY			
Frederick				1 days				Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Rockville							
Frederick Memorial Hospital				502 Lincoln Street							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		5. SEX		6. COLOR OR RA.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		4. DATE OF DEATH	
Philip Richard Lease		M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 12, 1913		Nov 25 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Truck Driver-WTA		Washington Technology		Maryland		USIA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address							
William Lease		Edith Kenny		Martha M. Lease 502 Lincoln St., Md Rockville							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)											
Yes WW II											
16. SOCIAL SECURITY NO. 17. INFORMANT											
Unknown Martha M. Lease											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 1/20/1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) unknown											
INTERVAL BETWEEN ONSET AND DEATH 4 hours											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19											
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/25 1966, to 11/25 1966, that (I) (we) last saw the deceased alive on 11/25 1966, and that death occurred at 3P M, from the causes and on the date stated above.											
22a. SIGNATURE											
Henry V. Chase											
22c. PHYSICIAN'S NAME (Type)											
Henry V. Chase 804 Toll House Ave Frederick Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 11-29-66											
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS											
Arlington Natl Cem. Arlington, Virginia											
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland											
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 30 1966 Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEP.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

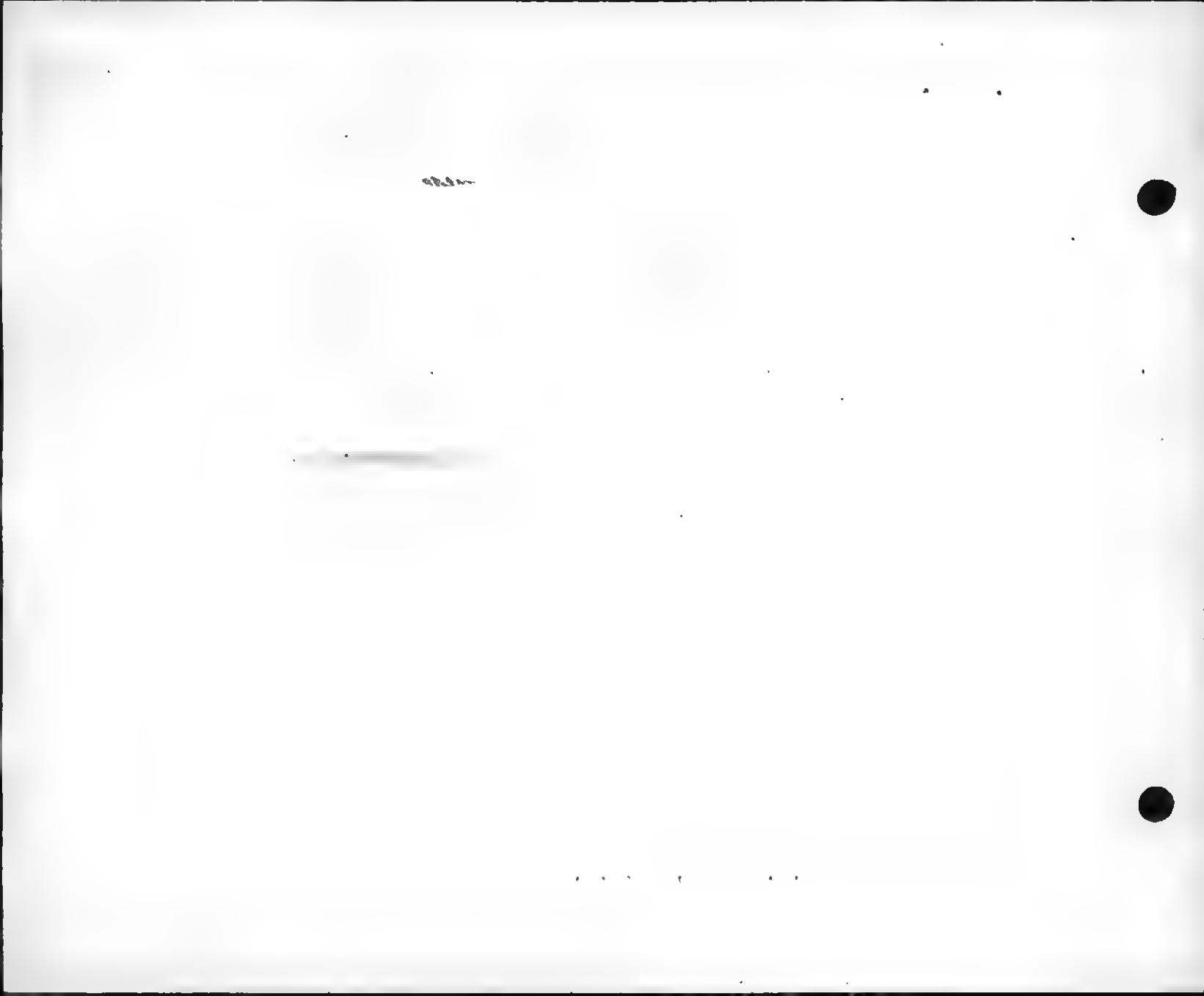
11 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15651

1 PLACE OF DEATH a. COUNTY FREDERICK		2 USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) b. STATE Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick Md.		c LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BERYL E		First B	Middle E
4 DATE OF DEATH Nov 6 1966		Month Nov	Day 6
5 SEX F	6 COLOR OR RACE W	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH Oct. 31 1908		9 AGE (In years last birthday) 58 yrs	F UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b KIND OF BUSINESS OR INDSTRY	I UNDER 24 HRS Hours 0
11. BIRTHPLACE (State or foreign country) Mississippi		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME ROSE KAUFER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT THEODORE LICHENSTEIN Address Frederick Md		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DOUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Massive Hemorrhage last.	
		(b) DOUE TO Lacerated Heart	
		(c) DOUE TO Fractured Ribs	
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Two car collision			
20c TIME OF MUR. Month, Day, Year Hour pm 11-1-1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f (City or town) In Brunswick		(County) Frederick	
		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Charles Judge	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 11-12-66	23c NAME OF CEMETERY OR CREMATORIAL RESTHAVEN
24 FUNERAL DIRECTOR SALAMONE FUNERAL HOME		23d LOCATION (City or Town) FREDERICK, MD	
		25a REC'D BY REGISTRAR Charles Judge	25b REC'D STAR'S SIGNATURE
		DATE NOV 10 1966	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

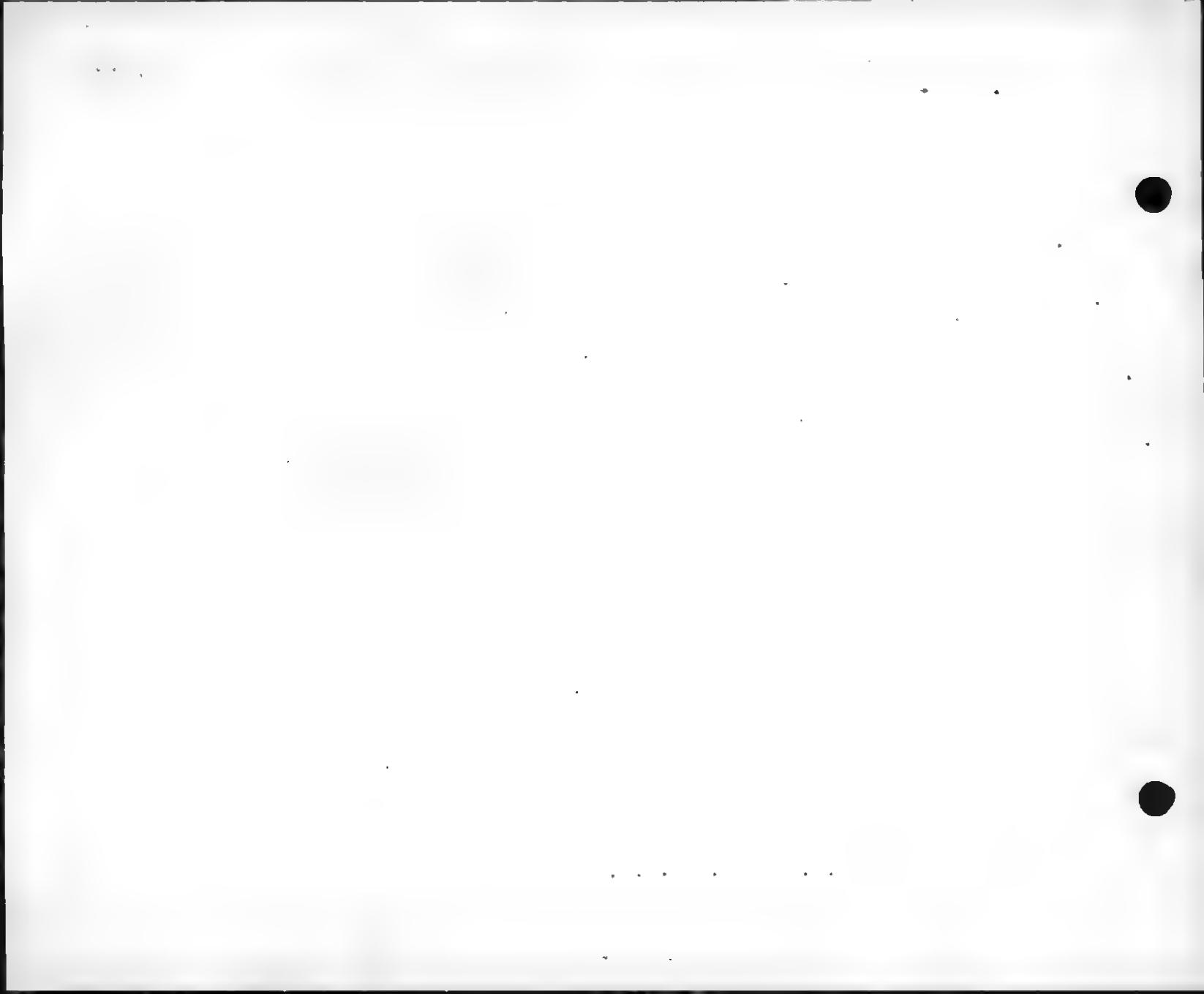
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15652

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE	
<i>Frederick</i> MARYLAND		Maryland	
b. CITY OR TOWN, If out of corporate limits, write RURAL and give nearest town) <i>Rural Brunswick</i>		c. LENGTH OF STAY N 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		d. STREET ADDRESS <i>Rt. # 7</i>	
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>THEODORE</i>		First <i>S.</i>	Middle <i>LICHTENSTEIN</i>
4 DATE OF DEATH <i>Nov 6 1966</i>	Month Year	Day	Year
5 SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <i>SEPT. 14, 1911 55 yrs</i>
9 AGE (In years lost birthday) Months <i>55 yrs</i>	10a USUA. OCC.PAT ON (Give kind of work done during most of working life even if retired) <i>Business man</i>	10b K ND OF BUSINESS OR INDUSTRY <i>Consultant</i>	11 BIRTHPLACE (State or foreign country) <i>Germany</i>
12 C ITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13 FATHER'S NAME <i>Unknown</i>		
14. MOTHER'S MAIDEN NAME <i>Unknown</i>	15. SOC A. SECURITY NO <i>Theodore Lichtenstein, Jr., Fred. Md.</i>		
16. INFORMANT <i>Address</i>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured Skull, Lacerated Brain</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Two car collision</i>	
20c. TIME OF INJURY Month Day Year Hour am <i>3:45 pm 11-6 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>
20f. (City or town) <i>Mr. Brunswick - Fred - Md.</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <i>Address</i>	
EXAMINER'S NAME (Type) <i>B.O.Thomas, SR.M.D.</i>		22. DATE SIGNED <i>11-6-66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-12-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Resthaven Cem</i>
24. FUNERAL DIRECTOR <i>SALAMONE FUNERAL HOME</i>		ADDRESS <i>FREDERICK, MD</i>	23d. LOCATION (City or Town) <i>Frederick Fred Md.</i>
		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
		DATE <i>NOV 10 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15650

15653

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wynelle Nursing Home

3. NAME OF
DECEASED
(Type or print)

First Ollie Middle Vitta

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

April 23-1881

DEATH

November 28- 1966

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.

85 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

Frederick County Md.

U. S. A.

13. FATHER'S NAME

Charles O. Phebus

14. MOTHER'S MAIDEN NAME

Sarah E. Burrier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

219- 20- 2280

17. INFORMANT

Laurens N. Bowers-

113 E. 7th. St.-Frederick

Address

Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage

Generalized arterio-sclerosis

INTERVAL BETWEEN
ONSET AND DEATH

3 days

10 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that (I) (this hospital) attended the deceased from Nov. 1, 1966 to Nov. 28, 1966, that (I) (we) last saw the deceased alive on Nov. 28, 1966, and that death occurred at 11:15a.m. from the causes and on the date stated above.

22a. SIGNATURE

Bernard O. Thomas Jr.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Bernard O. Thomas Jr.

22d. ADDRESS

Professional Bldg.- Frederick, Md. 21701

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec. 1-1966

23c. NAME OF CEMETERY OR CREMATORIAL

Mt. Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Md. 21701

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Elwood T. Etchison & Son

ADDRESS Whitmore

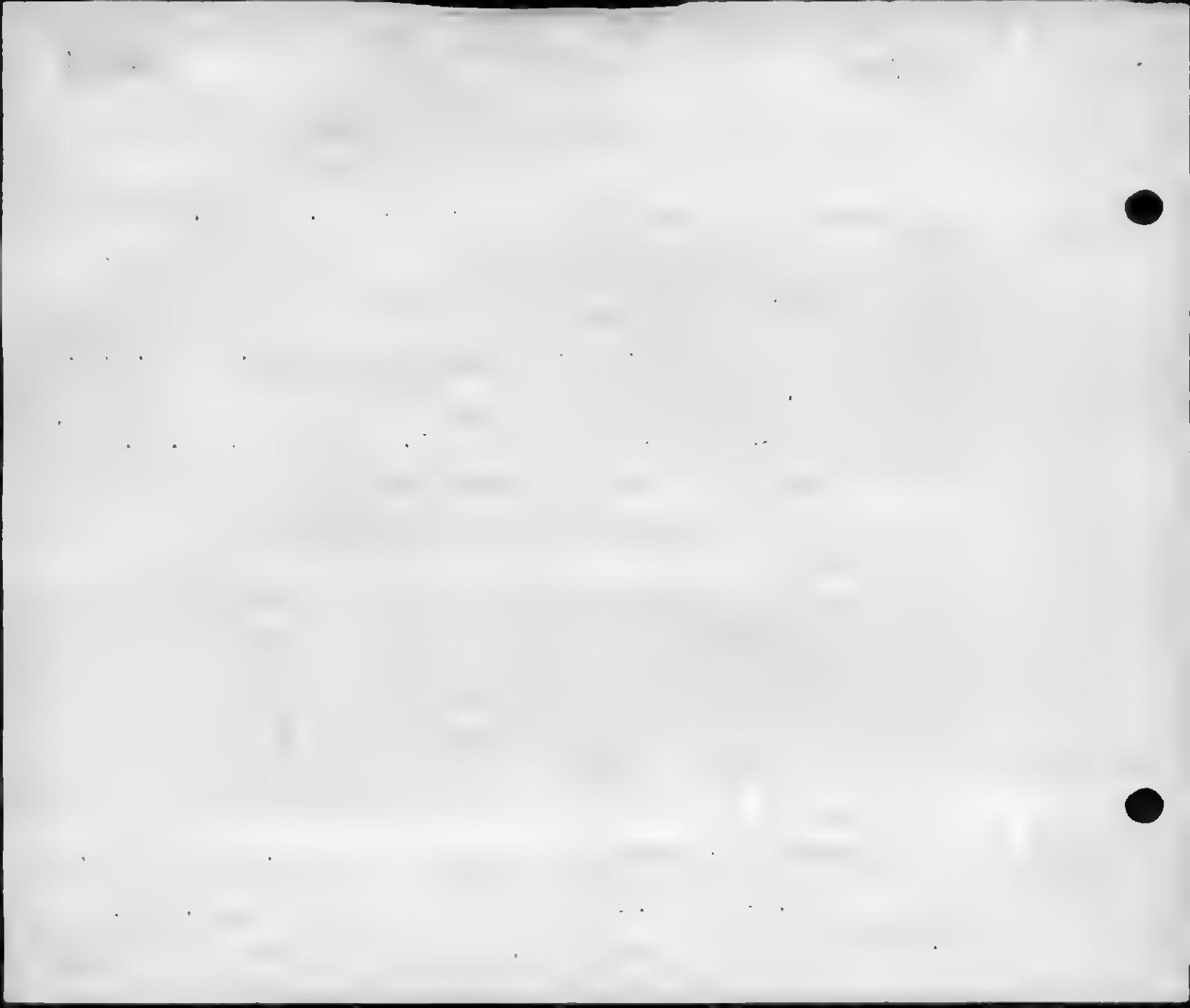
Frederick, Md. 21701

25a. REC'D BY REGISTRAR

DEC 1 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15651

CERTIFICATE OF DEATH

15654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Pose 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

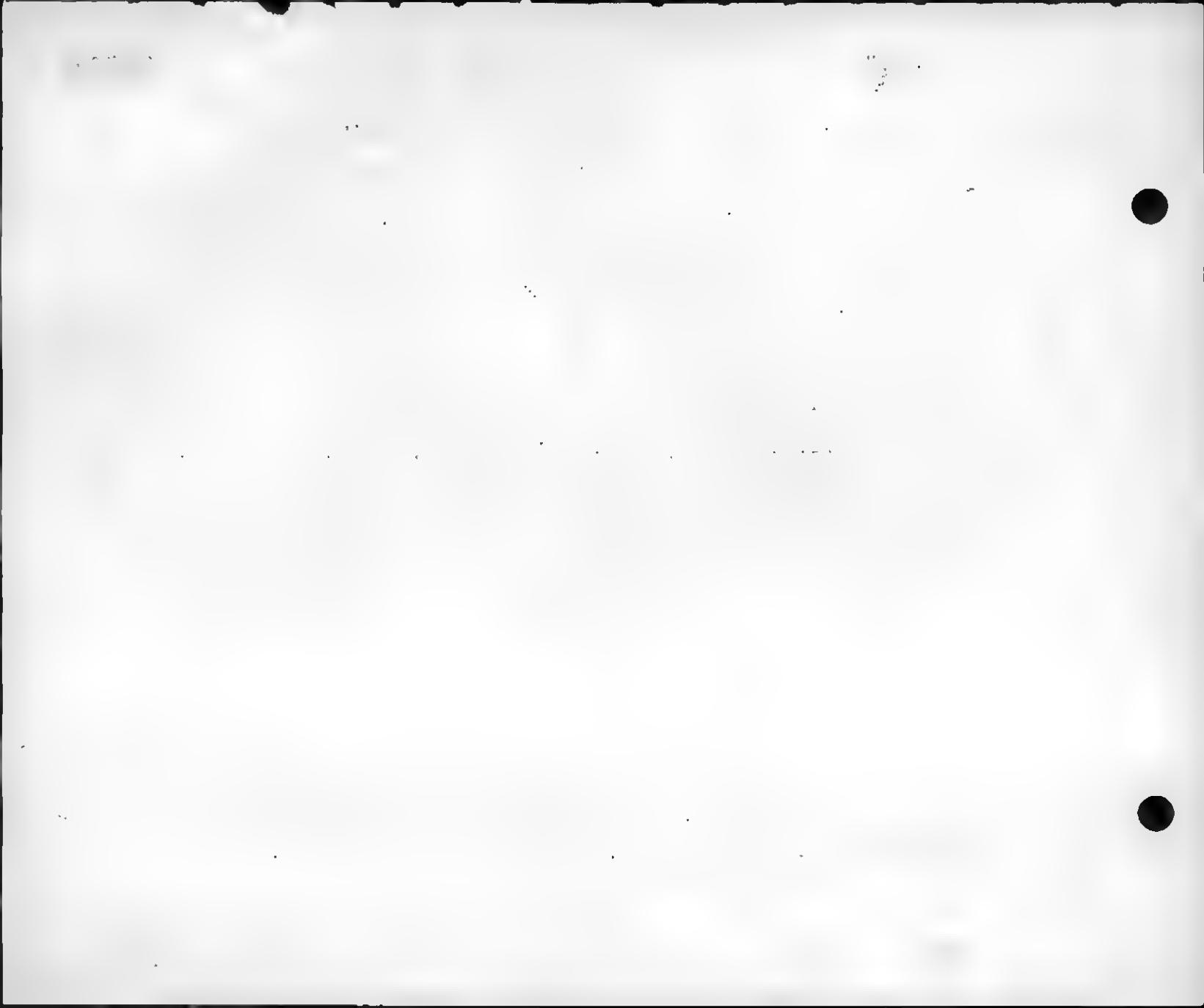
1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>always</i>		2. USUAL RESIDENCE (Where deceased lived, if inst. an Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Hagerstown</i>	
3. NAME OF DECEASED (Type or print)		First <i>Eleanor</i>	Middle <i>D.</i>	Last <i>Lorrie</i>	4. DATE OF DEATH	Month <i>Nov.</i>	Day <i>11</i>	Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> W-DOWED	8. DATE OF BIRTH <i>March 16-1896</i>	9. AGE (In years last birthday) <i>70 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Sarina Wareing</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Collier</i>		15. SOCIAL SECURITY NO. <i>058-01-9090</i>		16. INFORMANT Address <i>Mansfield-Sarina, Dickinson, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Heart Disease</i>		20. DUE TO (b) <i>Arteriosclerotic Heart Disease</i>		21. DUE TO (c)		22. year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 6, 1966</i> , to <i>Nov 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 10, 1966</i> , and that death occurred at <i>7:40 AM</i> , from causes and on the date stated above.									
22a. SIGNATURE <i>Henry V. Chase</i>		22b. DATE SIGNED <i>11 Nov 1966</i>							
22c. PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		22d. ADDRESS <i>804 Tell House Ave Frederick, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Valley</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick</i>			
24. FUNERAL DIRECTOR <i>William B. Hillary, Germantown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 10 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			15655		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE				b. COUNTY									
Frederick MARYLAND				Md.				Carroll									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Frederick				week				Woodbine, Md.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				Route 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Frederick Memorial Hospital																	
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year								
LILLIAN		C	MACE	NOVEMBER 22 1966													
5. SEX		6. COLOR OR RACE	7. MARRIED	<input type="checkbox"/> NEVER MARRIED	<input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.				
Female		White	WIDOWED	<input type="checkbox"/>	<input type="checkbox"/>	11-23-80	85 yrs.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Homemaking				Home				Maryland				USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
George A. Mace				Josephine Tusman													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No				212-01-2438				Mrs. B. D. Warfield				Woodbine, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ANEMIA - Pancytopenia Aplastic																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
19																	
21. I certify that (I) this hospital attended the deceased from 11/21, 1966, to 11/22, 1966, that (I) we last saw the deceased alive on 11/22, 1966, and that death occurred at 11 PM, from the causes and on the date stated above.																	
22a. SIGNATURE Richard C. Reynolds																	
22b. PHYSICIAN'S NAME Richard C. Reynolds MD				M.D. ATTENDING PHYS.				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				DATE SIGNED 11/22/66					
22c. ADDRESS				Frederick, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City, town or county) (State)					
Burial				11-25-66				Parkwood Cemetery				Baltimore Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Kathy W. Bright				Sykesville, Md.				NOV 28 1966				Charles J. ...					
20M 1/65																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15654

CERTIFICATE OF DEATH

15656

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mr. Urbana - Rural

c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route # 1, Ijamsville

MARYLAND

Years

3. NAME OF
DECEASED
(Type or print)

First

Middle

RUTH

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Mc FADYEN
August 12, 1903

9. AGE (In years
last birthday)

63 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

IF UNDER 1 YEAR
Months Days Hours Min.

Housewife

13. FATHER'S NAME

Daniel Tompkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

367 24 5534

14. MOTHER'S MAIDEN NAME

Jennie Richmond

Address

Norman B. McFadyen (Same as item # 2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. } (b)
} DUE TO
} (c)

Hypertension arterioclotic cardio
vascular disease

INTERVAL BETWEEN
ONSET AND DEATH

- 11 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Hour a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2-14-1956 to 11-3-1966, that (I) (we) last saw the deceased alive on 1966, and that death occurred at 9AM, from the causes and on the date stated above

22a. SIGNATURE

Rex R. Martin
M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. NOV. 4, 1966 SIGNED

22c. PHYSICIAN'S NAME (Type)

Rex R. Martin, M.D.

22d. ADDRESS
220 N. Market Street, Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
Nov. 7, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Resthaven Memorial Gardens

23d. LOCATION (City, town or county)

Hansonville, Maryland

(State)

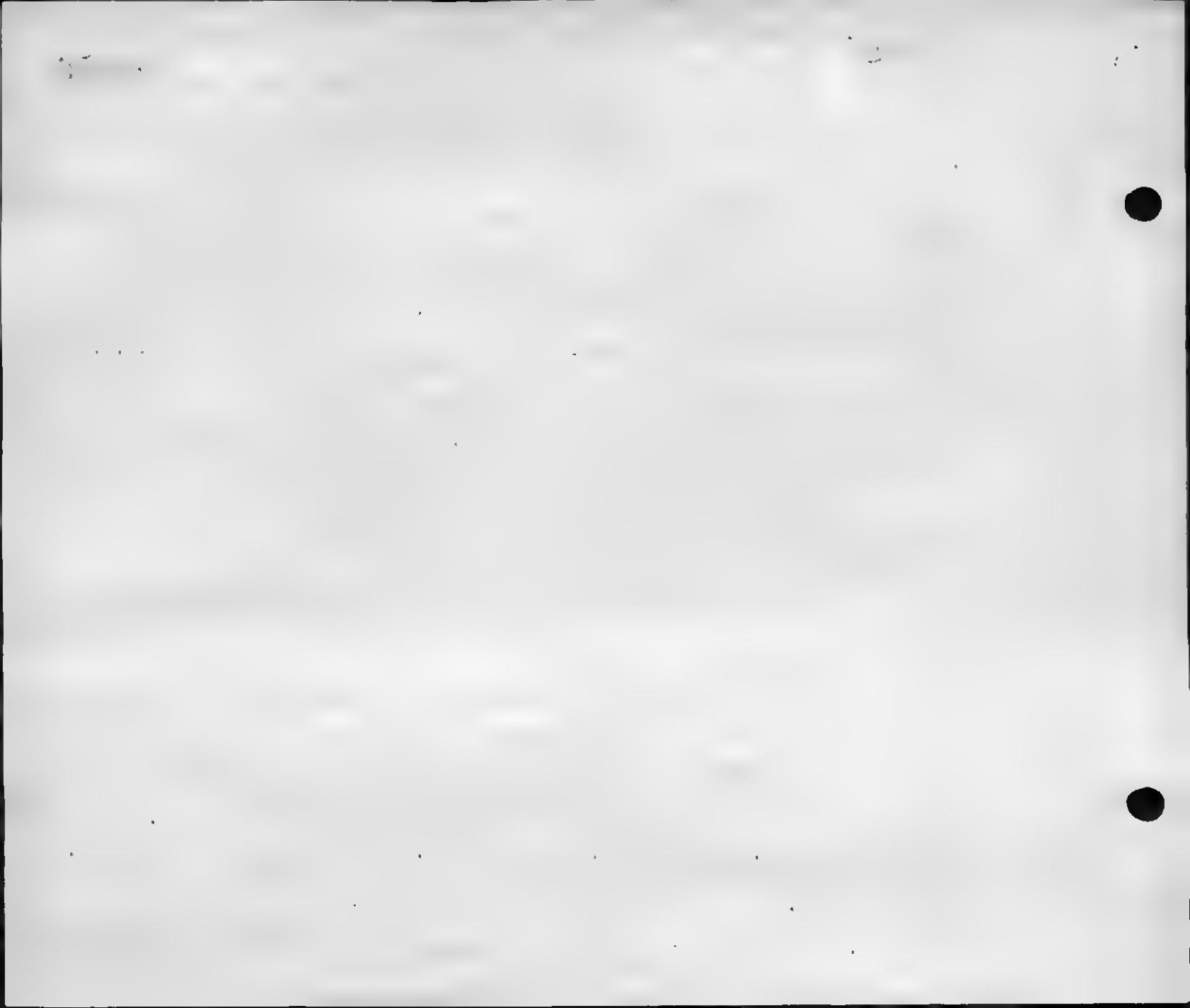
24. FUNERAL DIRECTOR'S SIGNATURE

Donald W. Fadley

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

NOV 10 1966 Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15655

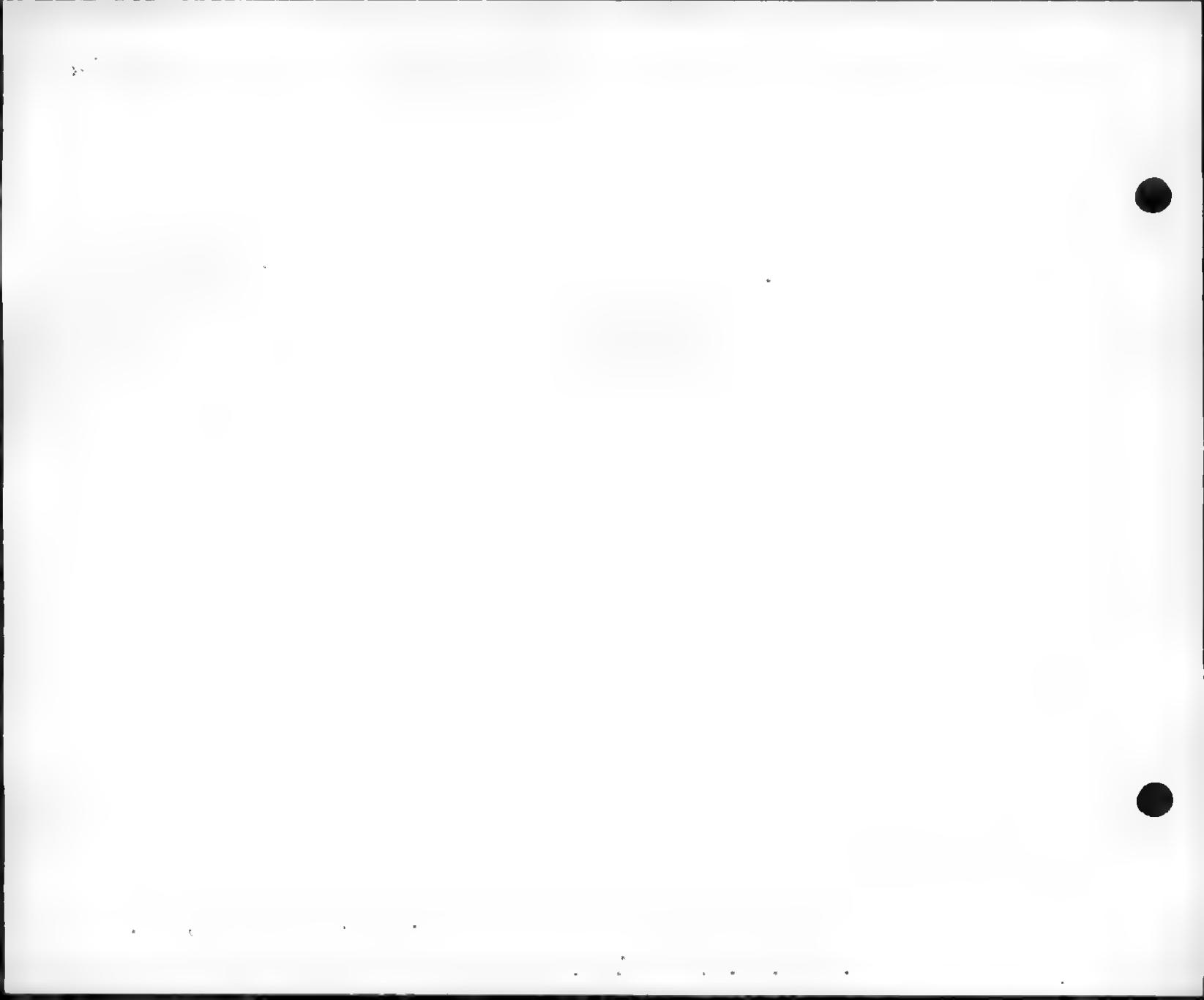
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15657

TO DENTAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

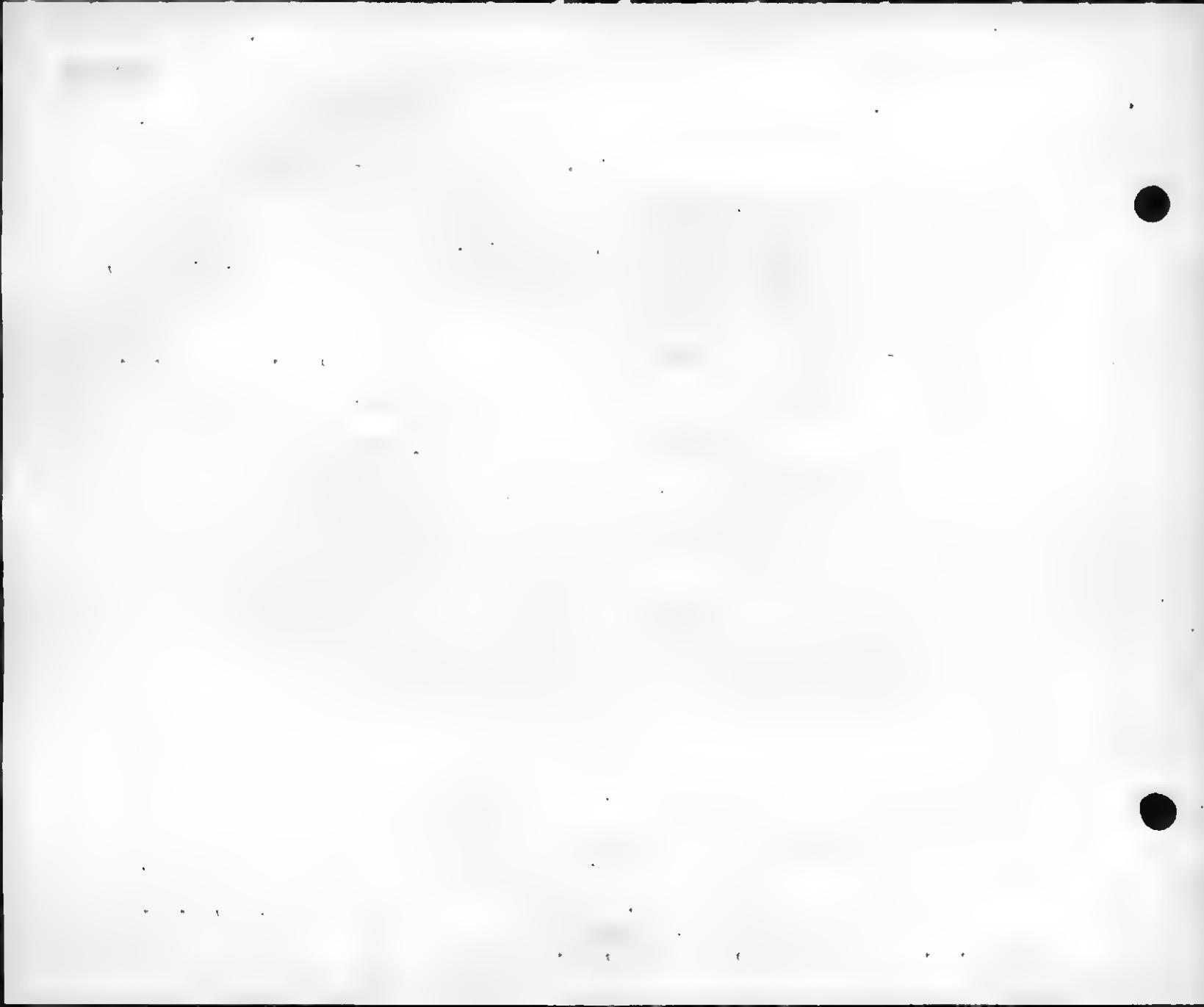
1. PLACE OF DEATH a. COUNTY <i>Grode rock</i>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town) <i>Knoxville R.D.T.</i>		c. LENGTH OF STAY IN lb <i>15 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS <i>Knoxville R.D.T.</i>	
3. NAME OF DECEASED (Type or print) <i>James Marshal McHugh</i>		First <i>J</i>	Middle <i>M</i>
4. DATE OF DEATH <i>November 7 1966</i>		Month <i>Nov</i>	Day <i>7</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>12/27/1899</i>		9. AGE (In years last birthday) <i>66 yrs</i>	10. IF UNDER 1 YEAR <i>Months</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Marine Colonel</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Austin McHugh</i>	
14. MOTHER'S MAIDEN NAME <i>Lutie Lindsay</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>yes 1941-2</i>	
16. SOCIAL SECURITY NO <i>- - -</i>		17. INFORMANT <i>Mr. Maguire McHugh</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO <i>Cardiols, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		<i>Arterosclerotic Heart Disease</i>	
(c) DUE TO <i>Hypertension</i>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.) <i>None</i>
20f. (City or town) <i>(County)</i>		(State) <i>(State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.L. Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>None</i>	
EXAMINER'S NAME (Type) <i>B.L. Thomas, M.D.</i>		22. DATE SIGNED <i>10/29/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-10-1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat'l. Cem. Arlington, Va.</i>	23d. LOCATION (City or Town) <i>(County)</i>
24. FUNERAL DIRECTOR <i>Joseph Gowler's Sons, Inc.</i>	ADDRESS <i>5130 Wisconsin Ave. N.W. Washington, DC.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15ME (5) 6M 1/66		DATE <i>NOV 14 1966</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15656 CERTIFICATE OF DEATH 15658									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 5 Yrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital					d. STREET ADDRESS Yellow Springs				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		ALICE First	LIGHTBOWN Middle	MCMANEMON Last	4. DATE OF DEATH	Month November	Day 12	Year 1966	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 June 1919	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Chester Lightbown					14. MOTHER'S MAIDEN NAME Marie (Last name unknown)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 222 03 6189 17. INFORMANT William E. McManemon (Same as item #2) Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Sherman, Alabama</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 5, 1966</i> to <i>Nov 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 11, 1966</i> , and that death occurred at <i>3:50 AM</i> , from the causes and on the date stated above.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE <i>Thomas E. Stone</i>					22b. DATE SIGNED <i>11-12-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>Thomas E. Stone</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Frederick, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>11/14/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Et. Lincoln Crematory</i>		23d. LOCATION (City, town or county) <i>Washington, D. C.</i> (State)			
24. FUNERAL DIRECTOR <i>Frank R. Smith</i> M. R. Etchison & Son, Frederick, Md. 21701					25a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>NOV 15 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

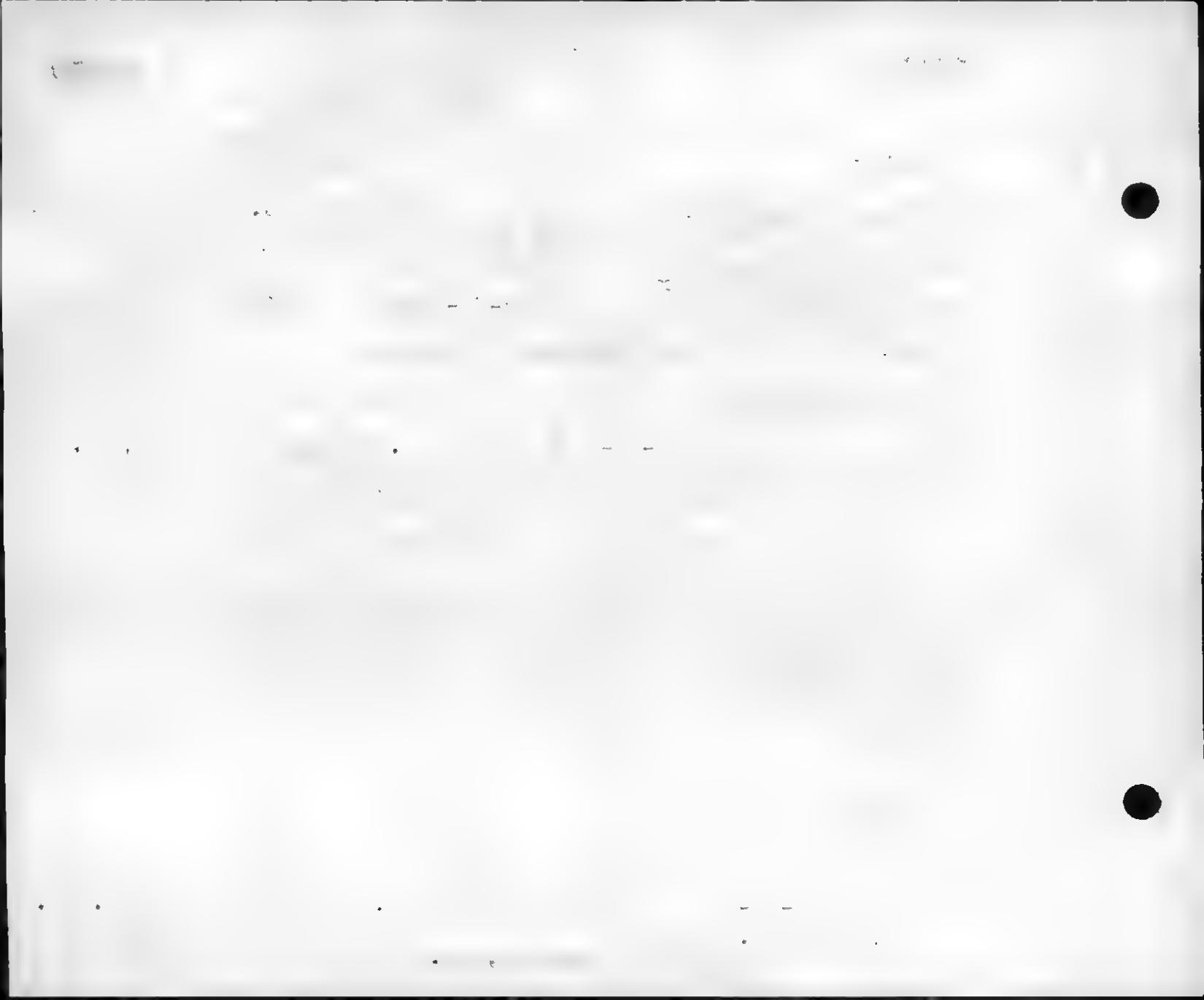
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15657

CERTIFICATE OF DEATH

15659

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Minute		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Carroll St.	
3. NAME OF DECEASED (Type or print)		First Raymond	Middle C.	Last Miller	4. DATE OF DEATH Nov. 25 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-1903	9. AGE (in years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Henry Miller		14. MOTHER'S MAIDEN NAME Clara Bell Fuss			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-2572		17. INFORMANT Luella M. Miller Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO 24 hr 420.1 Conditions, If any, which gave rise to immediate cause (a), stating the (b) arteriosclerotic heart disease DUE TO year underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick (County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 1966, to 11/25 , 1966, that (I) (we) last saw the deceased alive on 11/25 , 1966, and that death occurred at 10:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 11/25/66			
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave Frederick			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-27-66	23c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cemetery	23d. LOCATION (City, town or county) Thurmont Fred Co. Md. (State)	
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR NOV 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 15M 4-64					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

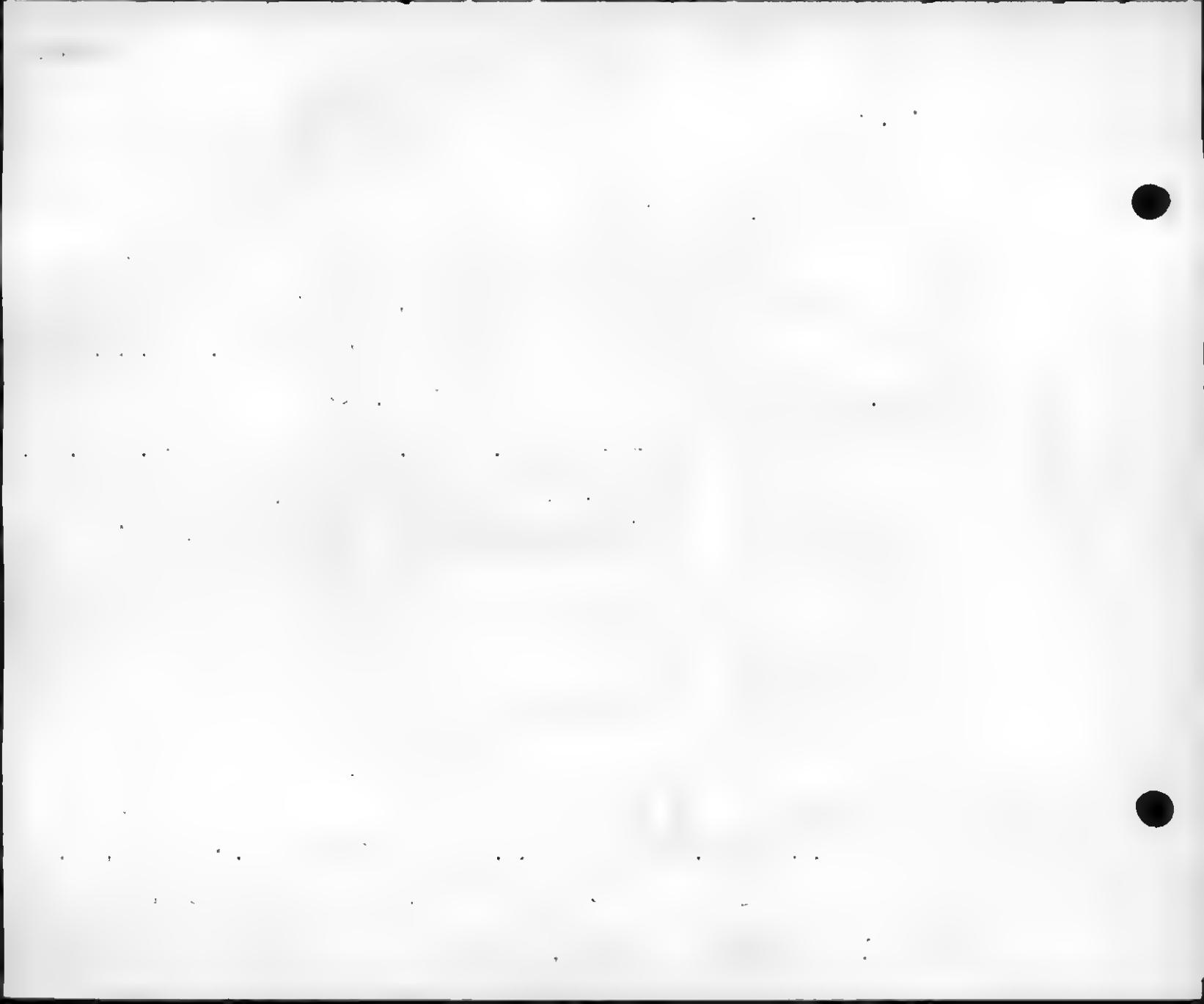
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 3, Given name and date of birth cert. 3/1/67-000 15660											
1. PLACE OF DEATH											
a. COUNTY Frederick MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick Since Birth											
c. LENGTH OF STAY IN 1D											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital											
3. NAME OF DECEASED C.R.S. No. First Name Middle Last 4. DATE OF DEATH Month Day Year											
DECEASED (Type or print) Baby Girl Monroe 11 / 18 1966											
5. SEX 6. COLOR OR RACE 1. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 2. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (in years last birthday) 10. UNDER 1 YEAR IF UNDER 24 HRS.											
W 11/15/66 Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)											
10b. KIND OF BUSINESS OR INDUSTRY											
11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?											
Frederick, Md. America											
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME											
Legally Unknown Gloria Jean Monroe Address											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT											
(Yes, no, or unknown) (If yes give war or dates of service) William Monroe. Monrovia, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE											
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) FIBROELASTOSIS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASPIRATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
Hour a.m. 11/15/66 While Not While at work at work											
21. I certify that (I) (this hospital) attended the deceased from 11-15, 1966, to 11-18, 1966, that (I) (we) last saw the deceased alive on 11-18 1966, and that death occurred at 2:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED 11/18/66											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)											
11-20-66 Forest Park Martinsburg, W. Va.											
24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
Ernest C. Gartner, Parkersburg, W. Va. DATE NOV 22 1966 Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15661		
CERTIFICATE OF DEATH												15661		
Item - 8 Film 0303 12/7/66														
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1B Frederick days			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE			b. COUNTY		
Frederick MARYLAND			Frederick						Maryland			Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			Frederick Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Frederick		
3. NAME OF OFCEASED (Type or print)			First ELSIE			Middle VIOLA			Last NORWOOD			4. DATE OF DEATH		
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (in years last birthday)		
Female			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			August 6, 1894			72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Homemaker			None			Montgomery County, Md.			U.S.A.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME											
Daniel R. Morningstar			Olive L. Hawes											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			214-24-6309			Mr. Earl E. Norwood			6 Norva Ave, Fred. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			longitudinal heart failure			INTERVAL BETWEEN ONSET AND DEATH 6 days					
			450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) due to (c) OUE TO Alterate tuberculosis, generalized								
20a. MEDICAL CERTIFICATION			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 8.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>11/18/66</u> to <u>11/24/66</u> , that (I) (we) last saw the deceased alive on <u>11/24/66</u> , and that death occurred at <u>305</u> M, from the causes and on the date stated above.														
22a. SIGNATURE			Robert S. Hughes			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 11-24-1966		
22c. PHYSICIAN'S NAME (Type)			Dr. Robert S. Hughes			M.D.			22d. ADDRESS 700 Montclair Ave. Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF Burial 11-28-1966			23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery			23d. LOCATION (City, town or county) Frederick, Maryland			(State)		
24. FUNERAL DIRECTOR			ADDRESS Robert E. Dalley & Son			25a. REC'D BY REGISTRAR NOV 28 1966			25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

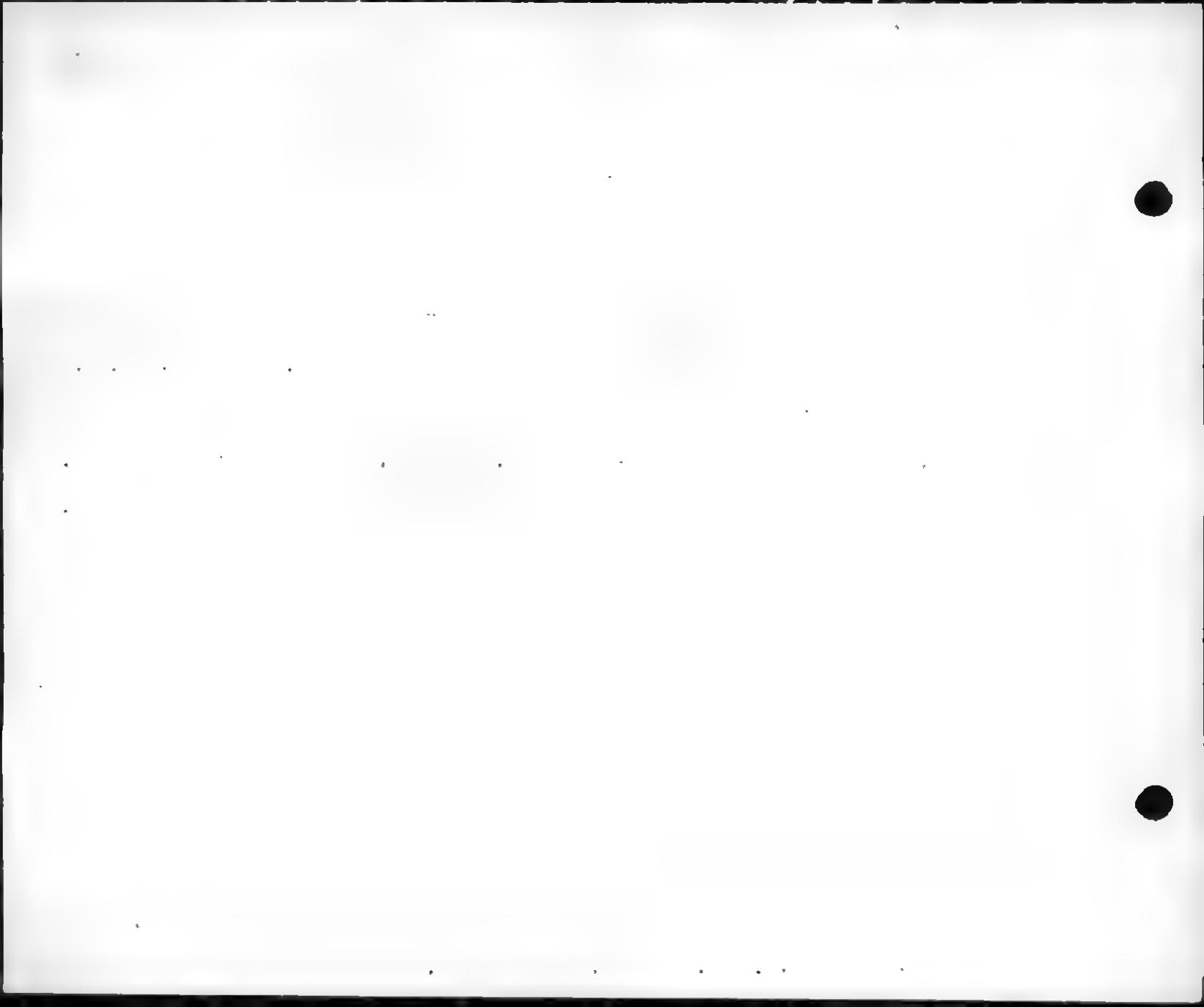
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Please give Page 10 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH								15662			
1 PLACE OF DEATH a. COUNTY Frederick				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville				b. COUNTY Washington							
c LENGTH OF STAY IN 1b Minutes				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Black Rock Road				d STREET ADDRESS				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First Joann	Middle Virginia	Last Physioc	4 DATE OF DEATH November 24, 1966	Month Day Year	Month Day Year	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

1

delay is
necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page
5 may be retained for your files.

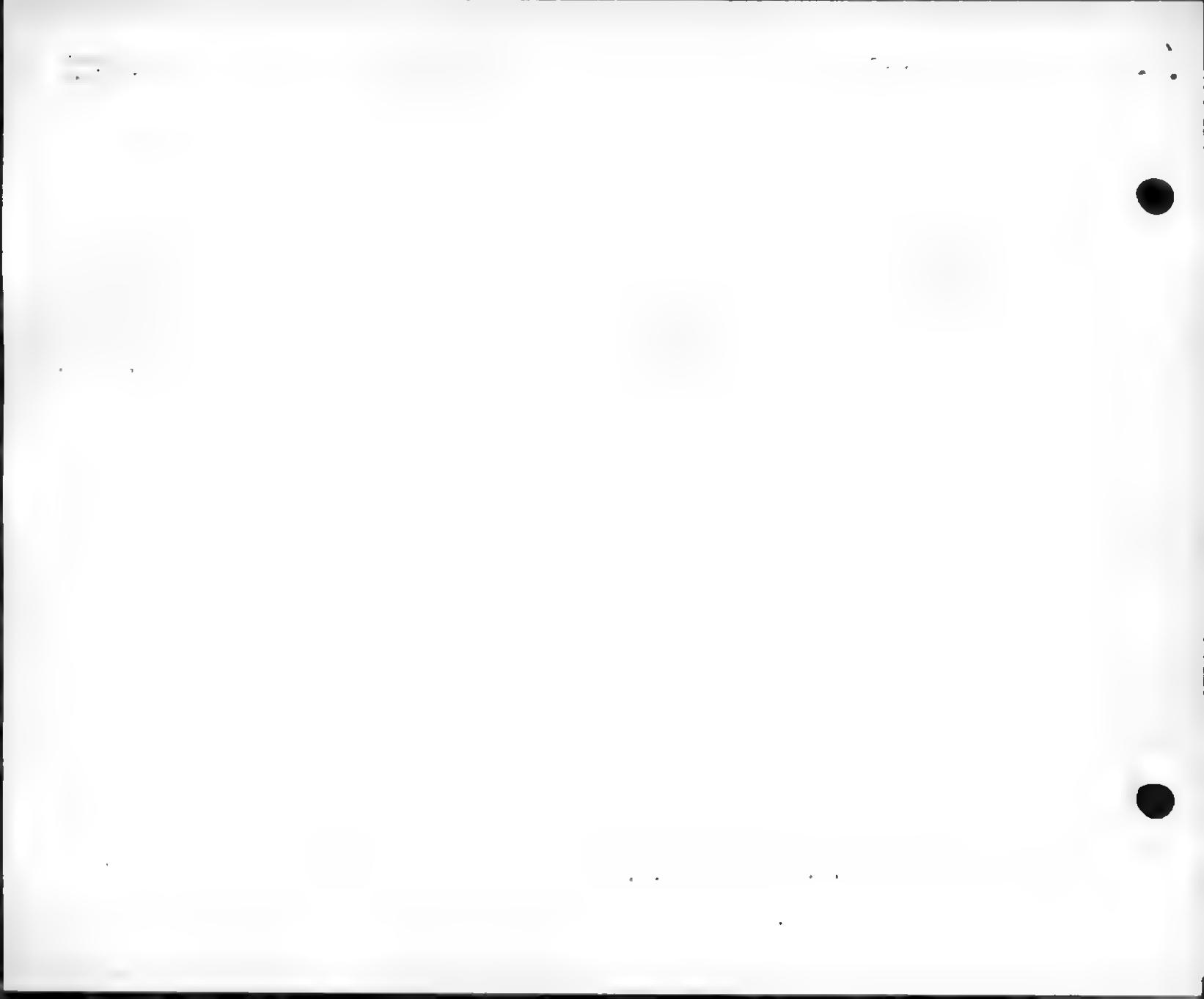
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

15661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15663

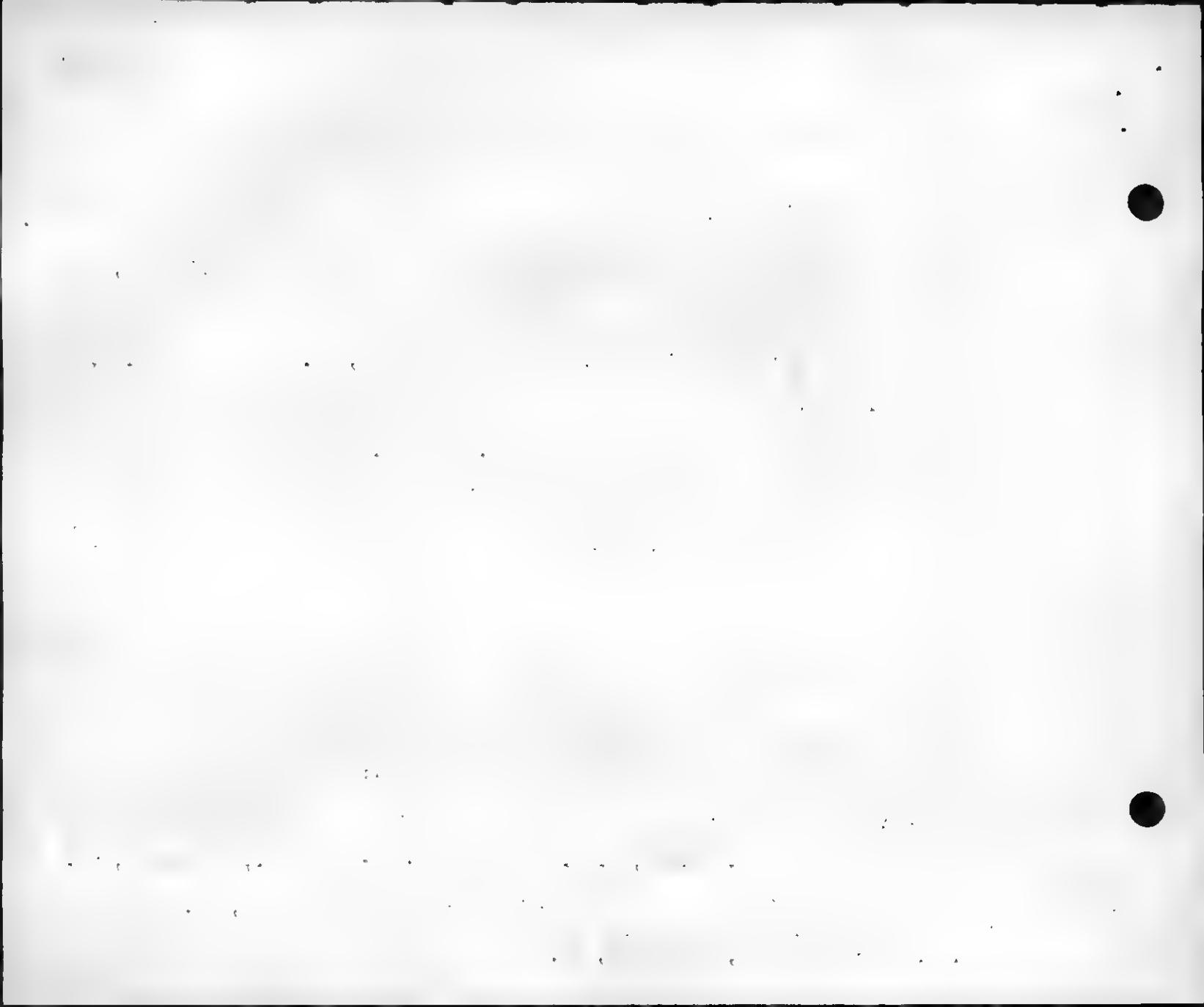
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 201 South Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GRACE	Middle IRLENE	Last PONELL
4. DATE OF DEATH Month November	Month 5	Day 1966	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH March 17, 1911
9. AGE (In years last birthday) 55 yrs	10. INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Zeno Brightwell	14. MOTHER'S MAIDEN NAME Mary Ellen Hargett	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOC. SECUR. NO	17. INFORMANT Leroy George Brightwell (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Amenia		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Bilateral Hydropsyche & Pyelonephritis		DUE TO (b) Bilateral Serous Cysts of Ovaries	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. CITY OR TOWN (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5 NOV 66
EXAMINER'S NAME (Type) B.O. Thomas, Sr.M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Court Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR Donald M. Etchison	ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15664	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Frederick				a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick									
c. LENGTH OF STAY IN lb Life				d. STREET ADDRESS 102 McMurray Street									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) NORA				First JANE	Middle RABE	Last	4. DATE OF DEATH November 15, 1966	Month Day Year					
5. SEX Female				6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Nov 1882	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Owner & Operator				10b. KIND OF BUSINESS OR INDUSTRY Gift Shop				11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jacob H. Deter				14. MOTHER'S MAIDEN NAME Georgianna Abrecht									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 103 12 3789D				17. INFORMANT Mrs. Norma E. Bruchey (Same as item #2)				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2102 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to 2102 Infected Small Bowel - Intestinal obstruction Post operative edema												? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 11-14, 1966 to 11-15, 1966, that (I) (we) last saw the deceased alive on 11-15, 1966, and that death occurred at 1:15 P.M. from the causes and on the date stated above.				22b. DATE SIGNED 16 Nov 1966									
22a. SIGNATURE Robert J. Thomas				22b. DATE SIGNED 16 Nov 1966									
22c. PHYSICIAN'S NAME (Type) Robert J. Thomas, M. D.				22d. ADDRESS 812 Toll House Ave., Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/18/66		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701				(State)	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701				25a. REC'D BY REGISTRAR NOV 18 1966								25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15663

15665

CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

5. SEX
female

Mary Magdalene

white

Roberts

6. COLOR OR RACE

7. MARRIED NEVER MARRIED b. DATE OF BIRTHWIDOWED DIVORCED

Nov. 12, 1902

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housekeeper

13. FATHER'S NAME

Grant Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

no

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Cynthia Collins, Neal Roberts, Libertytown, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Myocardial infarction, acute

Hypertensive arteriosclerotic cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH

5 days

SECOND

year

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 9, 1966, to Nov. 30, 1966, that (I)-(we) last saw the deceased alive on Nov. 30, 1966, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Ernest A. Dettbarn

M.D.

ATTENDING
PHYS.MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
11/30/6622c. PHYSICIAN'S
NAME (Type)

Ernest A. DETTBARN

22d. ADDRESS

Wallenville, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-4-1966

23c. NAME OF CEMETERY OR CREMATORIUM

Tennessee Valley Cem.

23d. LOCATION (City, town or county) (State)

Sneedsville, Tenn.

24. FUNERAL DIRECTOR'S SIGNATURE

Hartley & Sons

ADDRESS

Libertytown, Md.

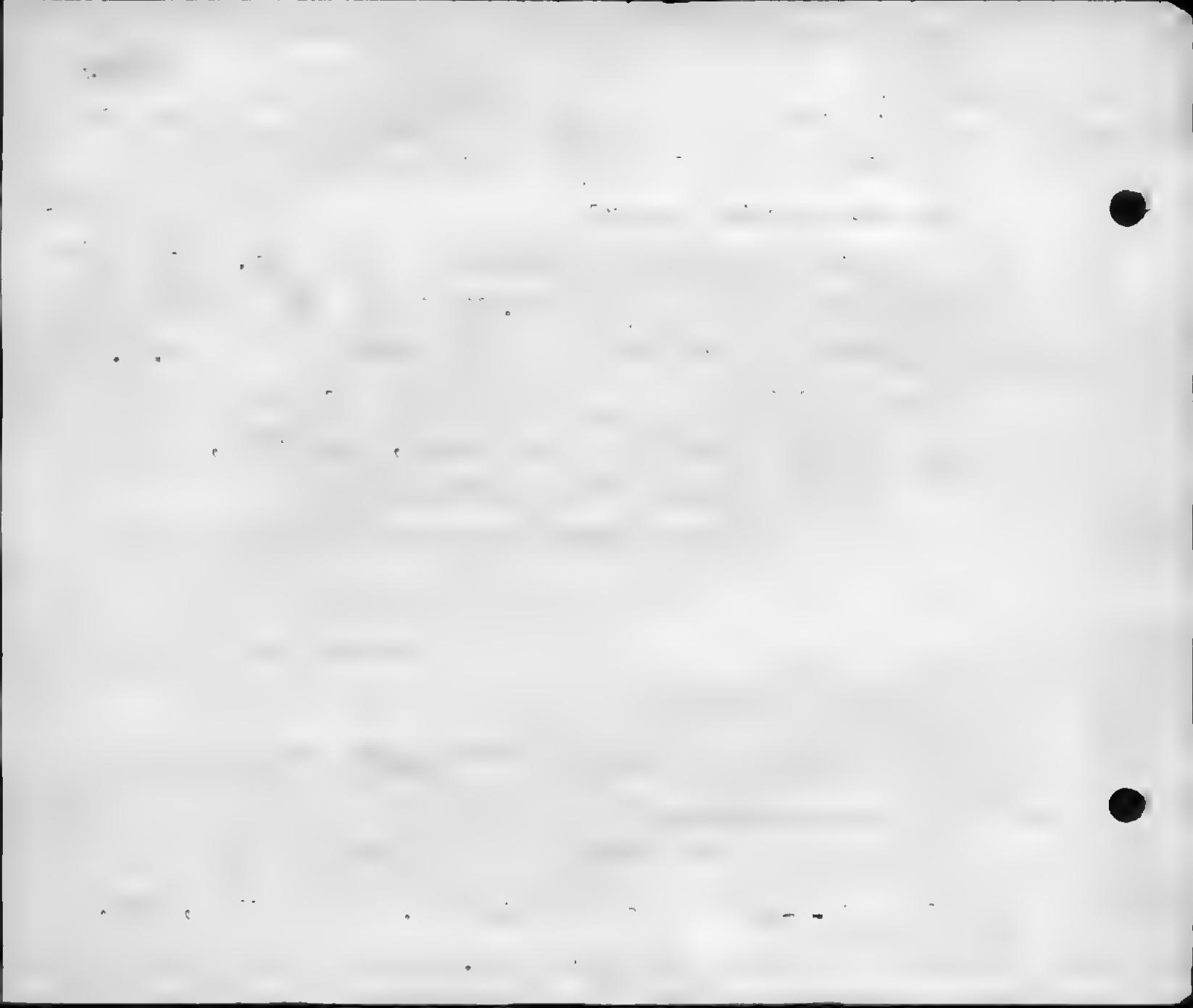
25e. REC'D BY REGISTRAR

DATE

DEC 2 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

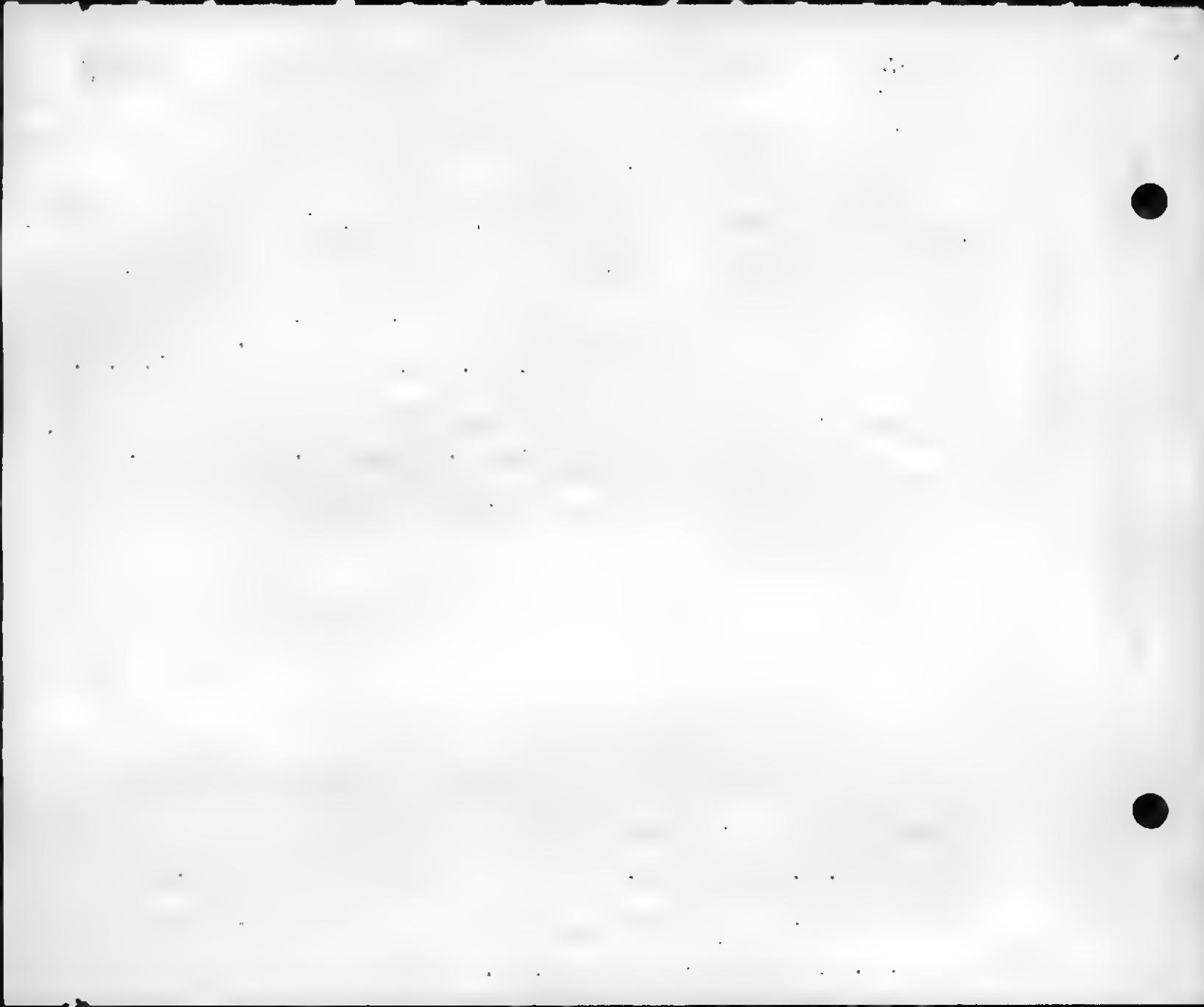


FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										MEDICAL EXAMINER'S CERTIFICATE OF DEATH		15666	
1. PLACE OF DEATH a. COUNTY Frederick					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland					c. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					c. LENGTH OF STAY IN 1D Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 275 West Fifth Street					d. STREET ADDRESS 275 West Fifth Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First MARY	Middle HELENA	Last SMITH	4. DATE OF DEATH Month November		Day 18	Year 1966				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 23, 1905	9. AGE (In years last birthday) 61 yrs.	10. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) St. Zion, Frederick County		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses aide		10b. KIND OF BUSINESS OR INDUSTRY Frederick Memorial Hospital		11. BIRTHPLACE (State or foreign country) St. Zion, Frederick County		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George H. Smith					14. MOTHER'S MAIDEN NAME Mary Ella Remsberg								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 218 34 3900		17. INFORMANT Evard C. Smith, 322 S. Jefferson St., Frederick		Address Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Suicide—carbon monoxide gas poisoning					INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jefferson	(County) Maryland	(State) Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> B. O. Thomas, M. D.			
ACTUAL SIGNATURE <i>B. O. Thomas</i>										M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.										Address (Street, city, town, or county) Nov. 18, 1966			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial					23b. DATE THEREOF Nov. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	23d. LOCATION (City, town or county) Jefferson, Maryland		(State) Md.				
24. FUNERAL DIRECTOR Howard M. Etchison & Son, Frederick, Md.					ADDRESS Fredley		25a. REC'D BY REGISTRAR NOV 21 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Images</i>	DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15665

CERTIFICATE OF DEATH

15667

1. PLACE OF DEATH a. COUNTY FREDERICK		Item 2 Information from Death Cert.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN MD 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Legore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First TERRY	Middle LEN	Last STACKHOUSE	4. DATE OF DEATH Nov 18 1966	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Nov 66	9. AGE (In years last birthday) yrs. 1	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Frederick MD	
13. FATHER'S NAME Clifton Monahan		14. MOTHER'S MAIDEN NAME Doris Stackhouse		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address Congenital Heart Disease (Type undetermined)			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		OUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) <input type="checkbox"/> this hospital attended the deceased from 13 Nov 66 , to 18 Nov 1966 , that (II) <input type="checkbox"/> last saw the deceased alive on 18 Nov 1966 , and that death occurred at 2:45 PM , from the causes and on the date stated above.		22b. DATE SIGNED 16 Nov 66			
22a. SIGNATURE R L Guest		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	ME.O. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R L Guest		22d. ADDRESS 6 W 3rd St Frederick MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 26 66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Paul B Cem	23d. LOCATION (City, town or county) (State) Thurmont Frederick MD	
24. FUNERAL DIRECTOR RAYMOND E. CREAMER		25a. REC'D BY REGISTRAR DATE NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15666

CERTIFICATE OF DEATH

15668

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b two days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route # 3 Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First LAURA	Middle BROWN	Last STALEY	4. DATE OF DEATH	Month November	Day 17	Year 1966
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1907	9. AGE (in years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Charles F. Brown	14. MOTHER'S MAIDEN NAME Laura R. Summers	Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 220-42-7406	17. INFORMANT Mr. Harry C. Staley
		Rt. # 3 Frederick, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Massive Left Cerebral Infarction
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	3 days
DUE TO (b)	Cerebral Artery Thrombosis
DUE TO (c)	Cerebral Arteriosclerosis
2 years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Hypertensive H.D.		3 "

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from Sept , 1966 to 11-17-1966 , that (I) (we) last saw the deceased alive on 11-17-1966 , and that death occurred at 5 p.m. M, from the causes and on the date stated above.
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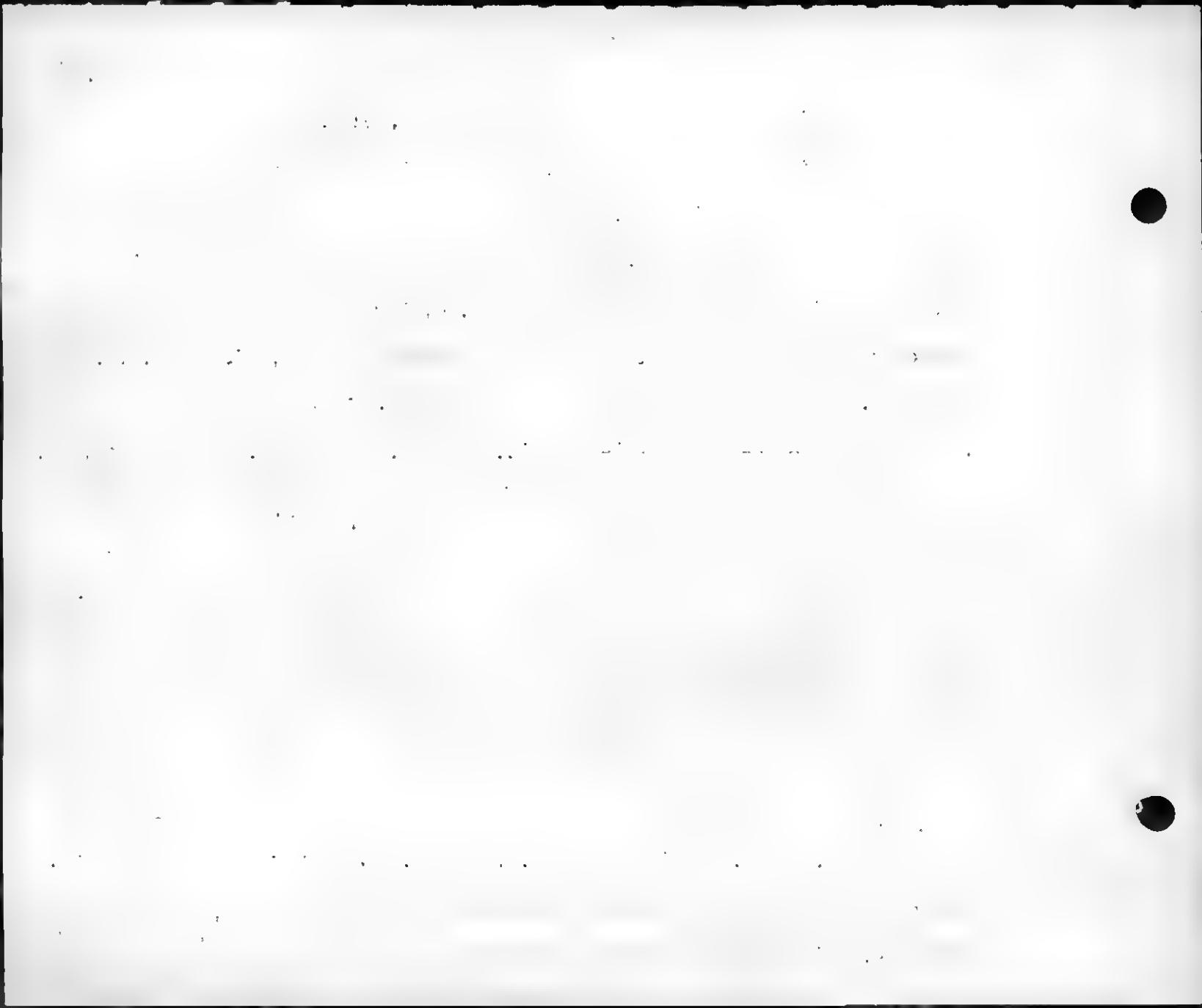
22a. SIGNATURE Rex R. Martin	22b. DATE SIGNED 11-17-1966
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-21-1966	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
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24. FUNERAL DIRECTOR Robert E. Dailey & Son	ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
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10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL ATTENDING PHYSICIAN

HOSPITAL OR ATTENDING PHYSICIAN: We further require that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15669

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
Frederick		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY Frederick	
Rural Emmitsburg,	83 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
R.D.# 1		R.D.# 1	
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		Martha	Ellen
4. DATE OF DEATH		Month	Day Year
November 16, 1966			
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED
Female	White	WIDOWED	<input checked="" type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	
May 3, 1883		83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Frederick Co. Md.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Frederick Co. Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Annias Ferguson		Carrie Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
No		215-20-9304 A Bernard Stouter, Emmitsburg, Md. R.D.#1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Myocardial Insufficiency		3 weeks	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Chronic Passive Congestion		6 months	
DUE TO (c) Arteriosclerotic Cardio-Vascular Disease		20 years	
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1966, to November 1966, that (I) (we) last saw the deceased alive on November 1966, and that death occurred at 11 AM, from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE		22b. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.	
James H. Hammeth MD		11-17-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
James H. Hammeth M.D.		Fairfield, Penn 17320	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Nov. 18, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
St. Joseph's Catholic		Emmitsburg, Md. Frederick Co.	
24. FUNERAL DIRECTOR Clarence E. Wilson		25a. REC'D BY REGISTRAR	
Clarence E. Wilson		25b. REGISTRAR'S SIGNATURE	
Emmitsburg, Md.		NOV 18 1966 Charles Judge	



2 2 2

2 2 2

2 2 2



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

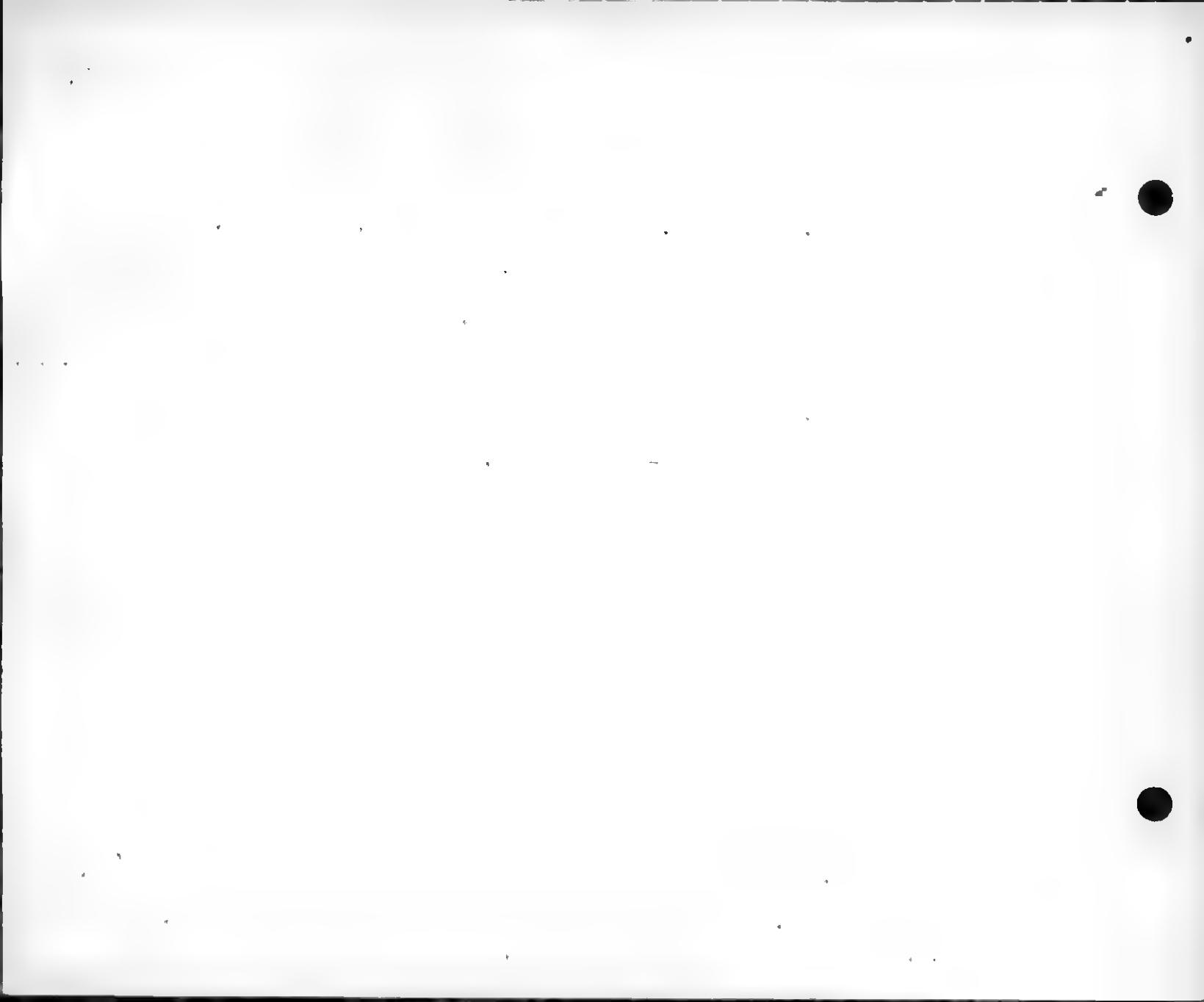
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15668

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15670

PLACE OF DEATH a. COUNTY Frederick MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 277 W. Patrick St.			d. STREET ADDRESS 277 W. Patrick St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Melvin Eugene Stull	First Melvin	Middle Eugene	LAST Stull	4. DATE OF DEATH Month November	Month 1 — 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED W. DIVORCED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>	B. DATE OF BIRTH Aug. 21-1916	9. AGE (In years lost birthday) 50 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even part time) Watch Repairing		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles E. Stull			14. MOTHER'S MAIDEN NAME Bernice Watts		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-12-1948		17. INFORMANT Address Mrs. Bernice Stull Straley- Same as 2 d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 42 11					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arterio sclerotic heart disease (c) DUE TO Obese					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Beth Thomas</i>	MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. B.O.Thomas			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4-1966	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	23d. LOCATION (City or Town) Frederick, Md. 21701	(County) Md.
24. FUNERAL DIRECTOR J.R.Etchison & Son		ADDRESS Whitmore	25a. REC'D BY REGISTRAR NOV 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Cn of Medical Examiner's Offce along with form PM3. Page 5 may be retained for your files.

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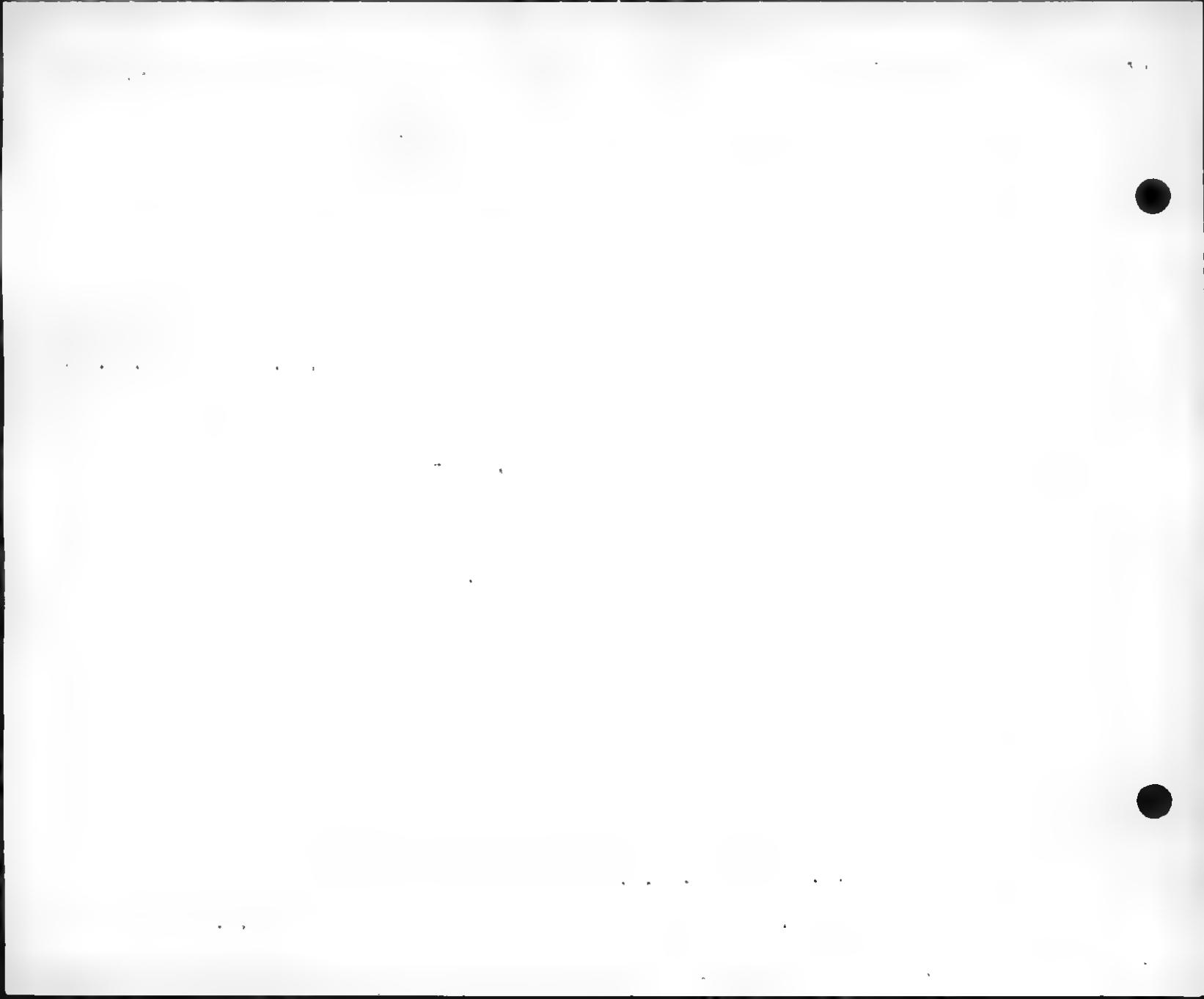
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15669

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15671

1. PLACE OF DEATH a. COUNTY Frederick			2 USUAL RESIDENCE (Where deceased resided, if institut or residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) Rural - Urbana			b. COUNTY Montgomery		
c. LENGTH OF STAY IN 1b 7 minutes			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) Highway near Urbana			d. STREET ADDRESS 513 Nelson Street		
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Peter	Middle Terzian	4 DATE OF DEATH Month November	Year Doy 19 1966
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 20, 1928	9 AGE (In years last birthday) yrs. 38
10a US AL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b KIND OF BUSINESS OR INDUSTRY Price Electric		11. BIRTHPLACE (State or foreign country) New York City, N. Y.	
13 FATHER'S NAME Aram Terzian			14. MOTHER'S MAIDEN NAME Sara Durgerian		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Lrs. Alice Terzian (Same as item # 2)	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Fractured Cervical-Thoracic Spine; Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost 2. Transected Aorta DUE TO (b) 3. Crushed Chest DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Collision of auto			
20c. TIME OF INJURY Month, Day, Year Hour min 5:15 pm 11-19 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, building, etc.) Highway	20f. (City or town) Mr. Urbana - Frederick - Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-19-66	
EXAMINER'S NAME (Type) B. O. Thomas, Sr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Bronx, N.Y.	
24. FUNERAL DIRECTOR Donald M. Fuddeley		ADDRESS N. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
VR A1SME (5) 6M 1/66		DATE NOV 22 1966			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15670

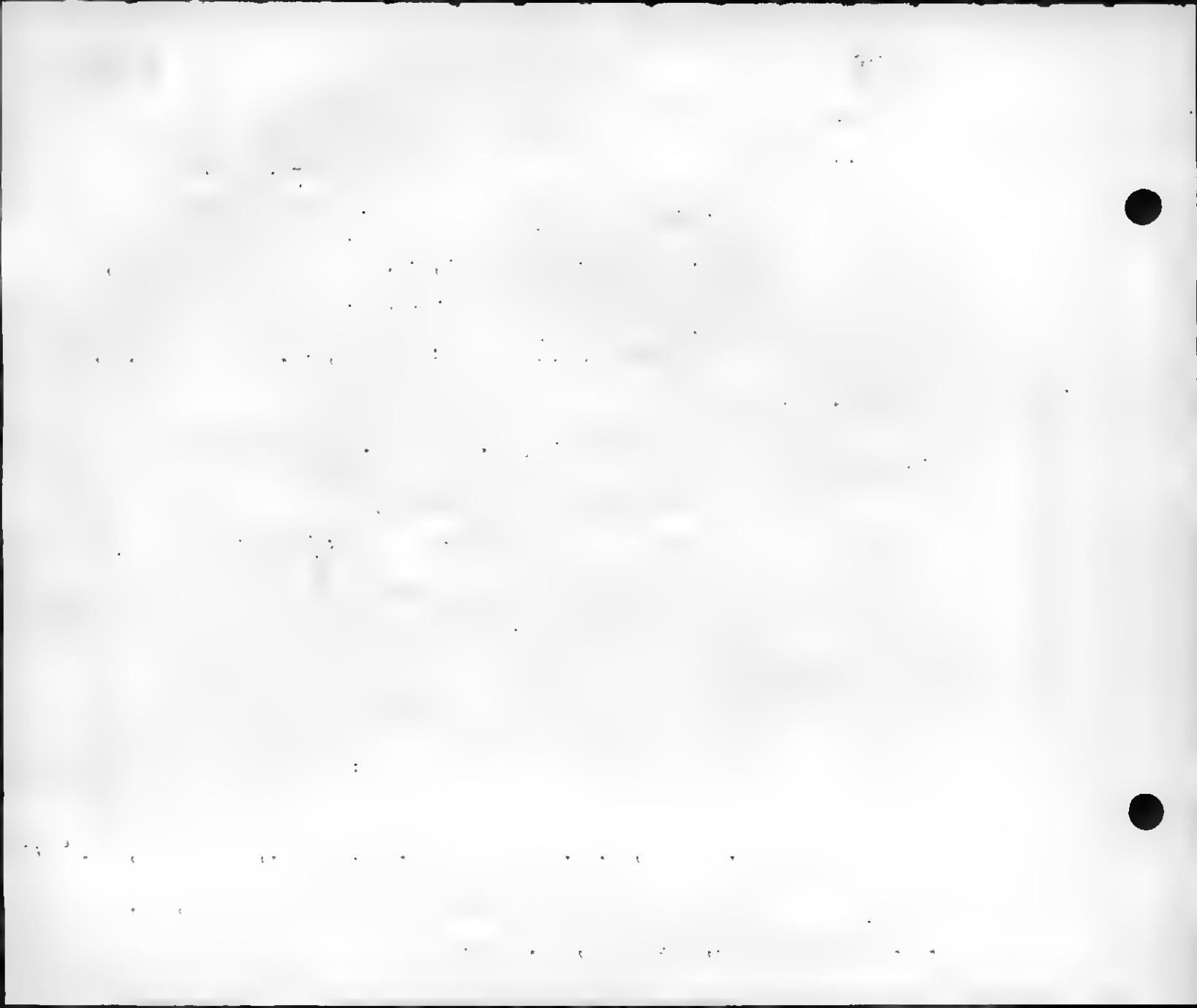
CERTIFICATE OF DEATH

15672

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2	
3. NAME OF DECEASED (Type or print) HERBERT EUGENE THOMPSON, JR.		4. DATE OF DEATH November 3, 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. OATE OF BIRTH 29 June 1922		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herbert B. Thompson		14. MOTHER'S MAIDEN NAME Mary Hawse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220 26 0255	
17. INFORMANT Mrs. Vergie L. Thompson (Same as item #2)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Excessive dilation of heart (c) Excessive arterial dilation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 72 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)
20f. (City or town) Frederick (County) Md. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1966 to 11/3 1966 , that (I) (we) last saw the deceased alive on 11/3 1966 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 4 Nov 1966	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Resthaven Memorial Gardens
23d. LOCATION (City, town or county) Hansonville, Md.		(State)	
24. FUNERAL DIRECTOR Frank R. Smith Jr.		25a. REC'D BY REGISTRAR NOV 7 1966	25b. REGISTRAR'S SIGNATURE J Charles Judge
M. R. Etchison & Son, Frederick, Md. 21701		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15671

CERTIFICATE OF DEATH

15673

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

c. LENGTH OF STAY IN 1b

7 yrs

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1426 W. 11th, Street

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

WILLIAM

ARTHUR

THRONE

4. DATE
OF
DEATH

Nov.

Month

Day

Year

1966

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Salesman

10b. KIND OF BUSINESS OR INDUSTRY

None

7. MARRIED NEVER MARRIED

b.

DATE OF BIRTH

October 13, 1882

84

yrs.

9. AGE (In years
at birthday) IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

11. BIRTHPLACE (County & State, or foreign country)

Milwaukee, Wisconsin

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William E. Throne

14. MOTHER'S MAIDEN NAME

Rose Ellen Naylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

393-003-1301A

17. INFORMANT

Address

Mr. J. Arthur Throne Rt. # 5 Frederick, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

443X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Hypertensive Cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept. 15, 1956 to Nov. 22, 1966, that (I) (we) last saw the deceased alive on Nov. 22, 1966, and that death occurred at 10:59 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas E. Stone

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

11-23-66

22c. PHYSICIAN'S
NAME (Type)

Thomas STONE

22d. ADDRESS

Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

11-23-1966

23b. DATE THEREOF

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Robert E. Dailey & Son

ADDRESS

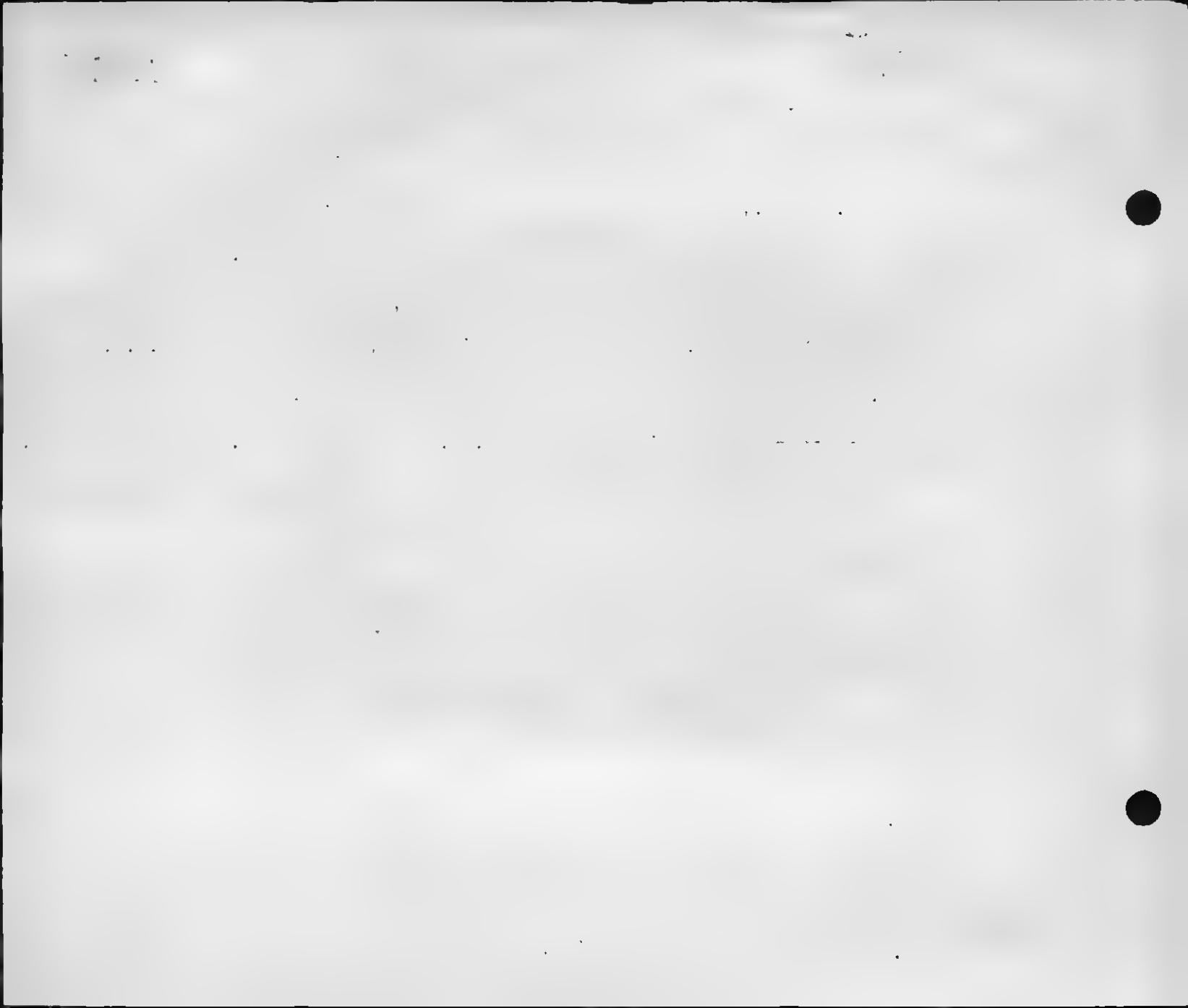
Frederick, Maryland

25e. REC'D BY REGISTRAR

NOV 28 1966

25b. REGISTRAR'S SIGNATURE

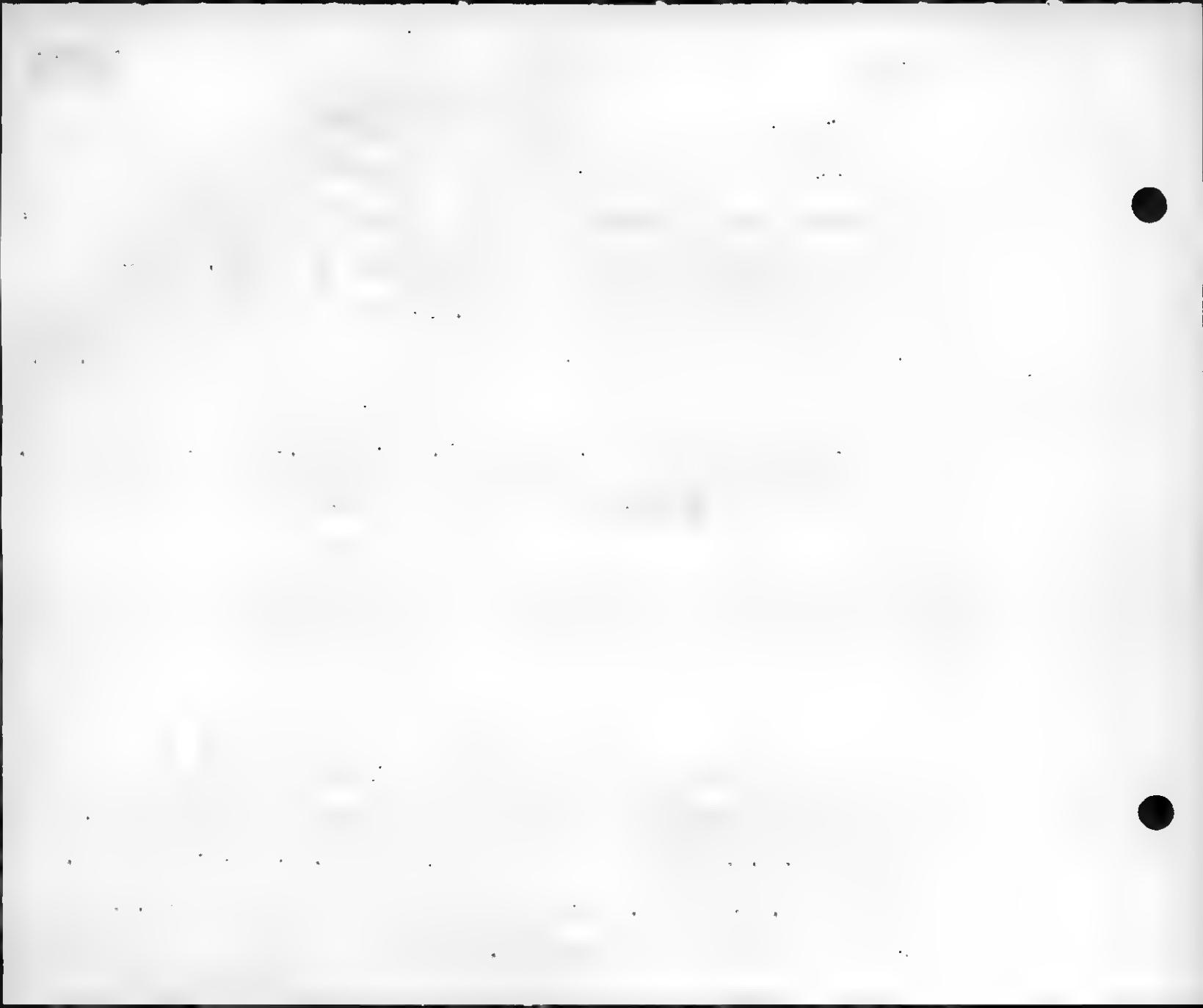
Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15674			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY		a. STATE Maryland b. COUNTY Frederick													
Frederick MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b													
Frederick															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?													
Frederick Memorial Hospital		Route 5 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
Female		Helen	Futch	Tribble	Nov.	12-	19	66							
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.			
Female		White	WIDOWED	Divorced	Feb. 14-1896	70 yrs.									
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Homemaker						Lak City- Florida			U.S.A.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
James Futch		Talulah Jernigan													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		261-52-6967		Henry R. Tribble-Jr.-Route 5-Frederick, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Amyotrophic Lateral Sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 3 years															
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		(b)		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County)		(State)							
19		Not While at work													
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 5, 1966</i> to <i>Nov. 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 11, 1966</i> , and that death occurred at <i>12:10 P.M.</i> from the causes and on the date stated above.															
22a. SIGNATURE <i>W.J. Riddick</i>															
22c. PHYSICIAN'S NAME (Type)		Dr. W.J. Riddick		M.D. ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED <i>11-12-66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Nov. 14-1966		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		23d. LOCATION (City, town or county) Washington 18- D.C.		(State)							
Cremation															
24. FUNERAL DIRECTOR <i>Elwood T. Etchison</i>		ADDRESS <i>Mitmore</i>		25a. REC'D BY REGISTRAR <i>NOV 14 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
M.R. Etchison & Son		Frederick, Md. 21701		DATE											



FOR STATE
HEALTH DEPT.

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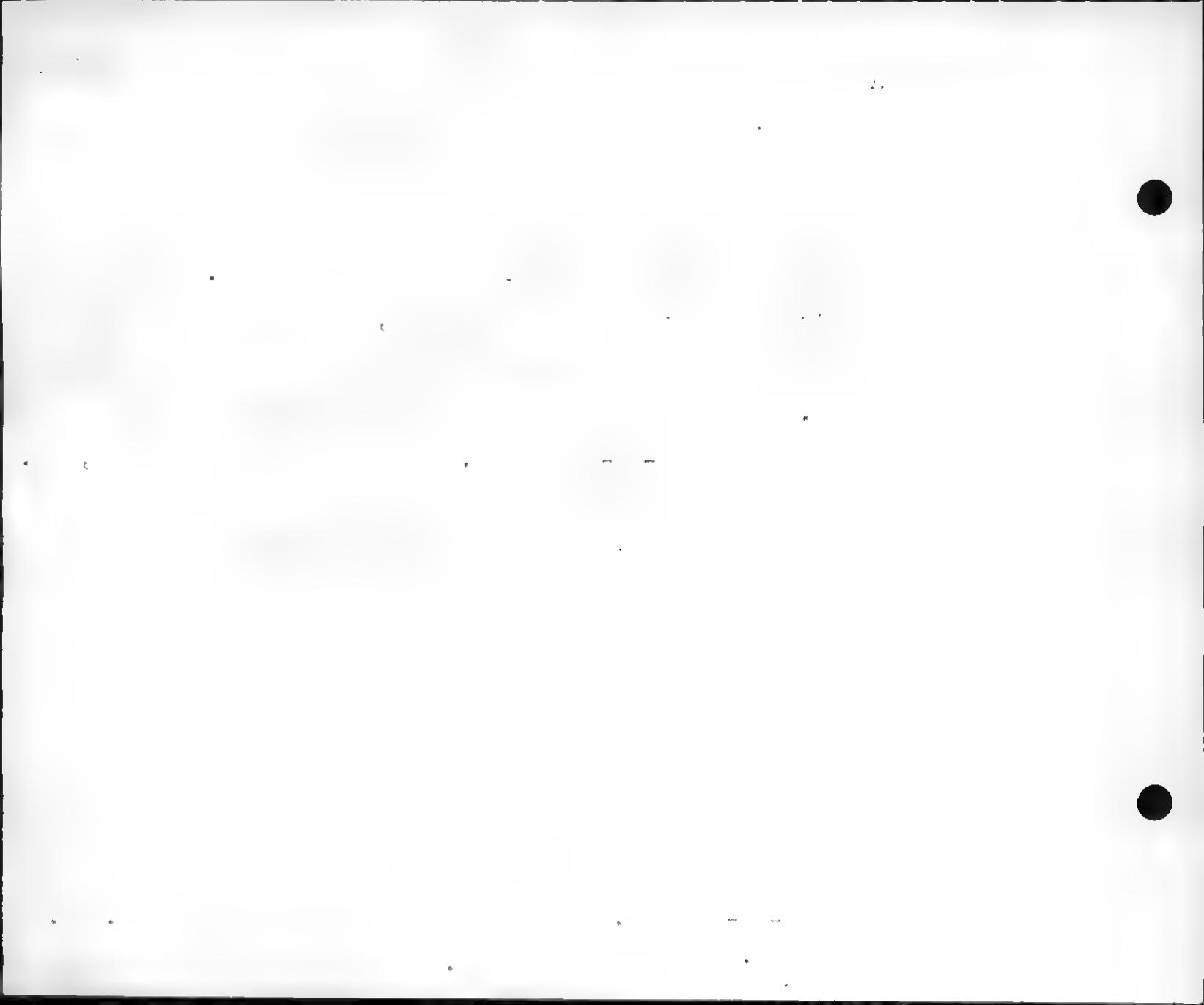
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15675

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c LENGTH OF STAY IN lb Lifetime	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d STREET ADDRESS	
e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Charles Roland Trexell		First Charles	Middle Roland
4 DATE OF DEATH Nov. 20 1966	Month Nov.	Day 20	Year 1966
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH March 16, 1907	9 AGE (In years last birthday) 59 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Carpenter	10b KIND OF BUSINESS OR INDUSTRY WMRR retired
11. BIRTHPLACE (State or foreign country) Maryland	12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Clayton J. Trexell	14. MOTHER'S MAIDEN NAME Mary Catherine Lawrence	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOC. SEC. NO. 705-10-5782	17. INFORMANT Mrs. Charles Masemore Thurment, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 176X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		INTERVAL BETWEEN ONSET AND DEATH	
Suicide Gunshot wounds of skull and brain			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE BC Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) BC Thomas, M.D.		22. DATE SIGNED NOV 23 1966	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-23-66	23c NAME OF CEMETERY OR CREMATORIUM Mt. Taber Cemetery
23d LOCATION (City or Town) Rocky Ridge Fred. Co. Md		(County) (State)	
24 FUNERAL DIRECTOR Raymond E. Greger Thurment Md.		ADDRESS	
25a REC'D BY REGISTRAR NOV 23 1966		25b REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 6M 1/66			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15674

15676

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

8 months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

P.O. Boyds

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Sallie

E.

Umstead

November

11

- 1966

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

Female

White

WIDOWED

DIVORCED

July 10-1880

86

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Collinson White

14. MOTHER'S MAIDEN NAME

Grace Botler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-54-6964

17. INFORMANT

Address

Mrs. Grace Horine- Boyds, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DOUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DOUE TO

(c)

Cerebral vascular accident

5 days

Arteriosclerotic cardiovascular disease

10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to Nov. 14, 1966, that (I) (we) last saw the deceased alive on Nov. 11, 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

LeRoy T. Davis

22b. DATE SIGNED

Nov. 15, 1966

22c. PHYSICIAN'S NAME (Type)

Dr. LeRoy T. Davis

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Prof. Bldg. Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

Burial

Nov. 13-1966

Ionocacy Cemetery

23d. LOCATION (City, town or county) (State)

Beallsville, Md.

24. FUNERAL DIRECTOR ADDRESS

Elwood T. Whitmore

H.R. Etchison & Son

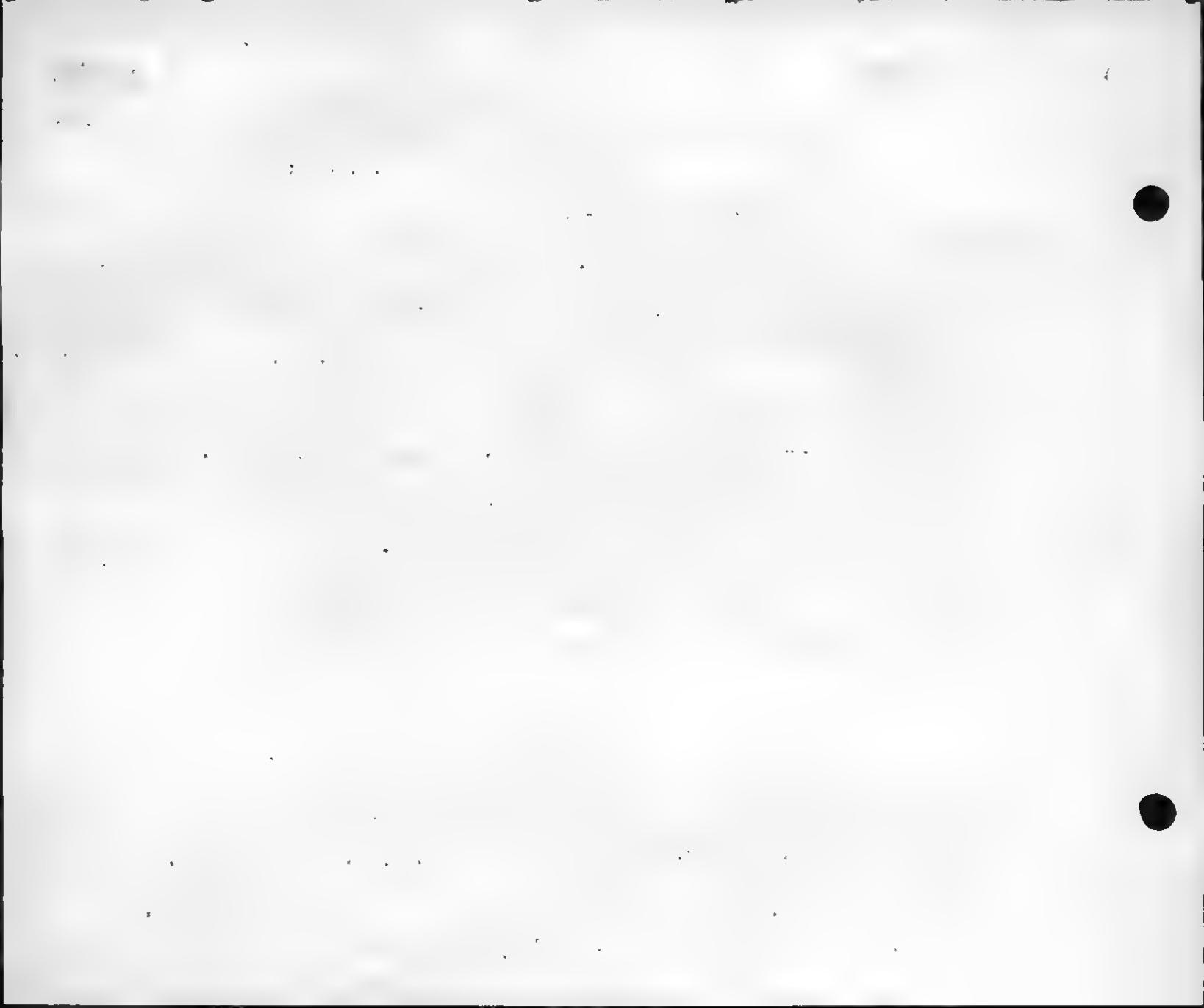
Frederick, Md. 21701

25a. REC'D BY REGISTRAR

NOV 15 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



FOR STATE
HEALTH-DEPT.

TO EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

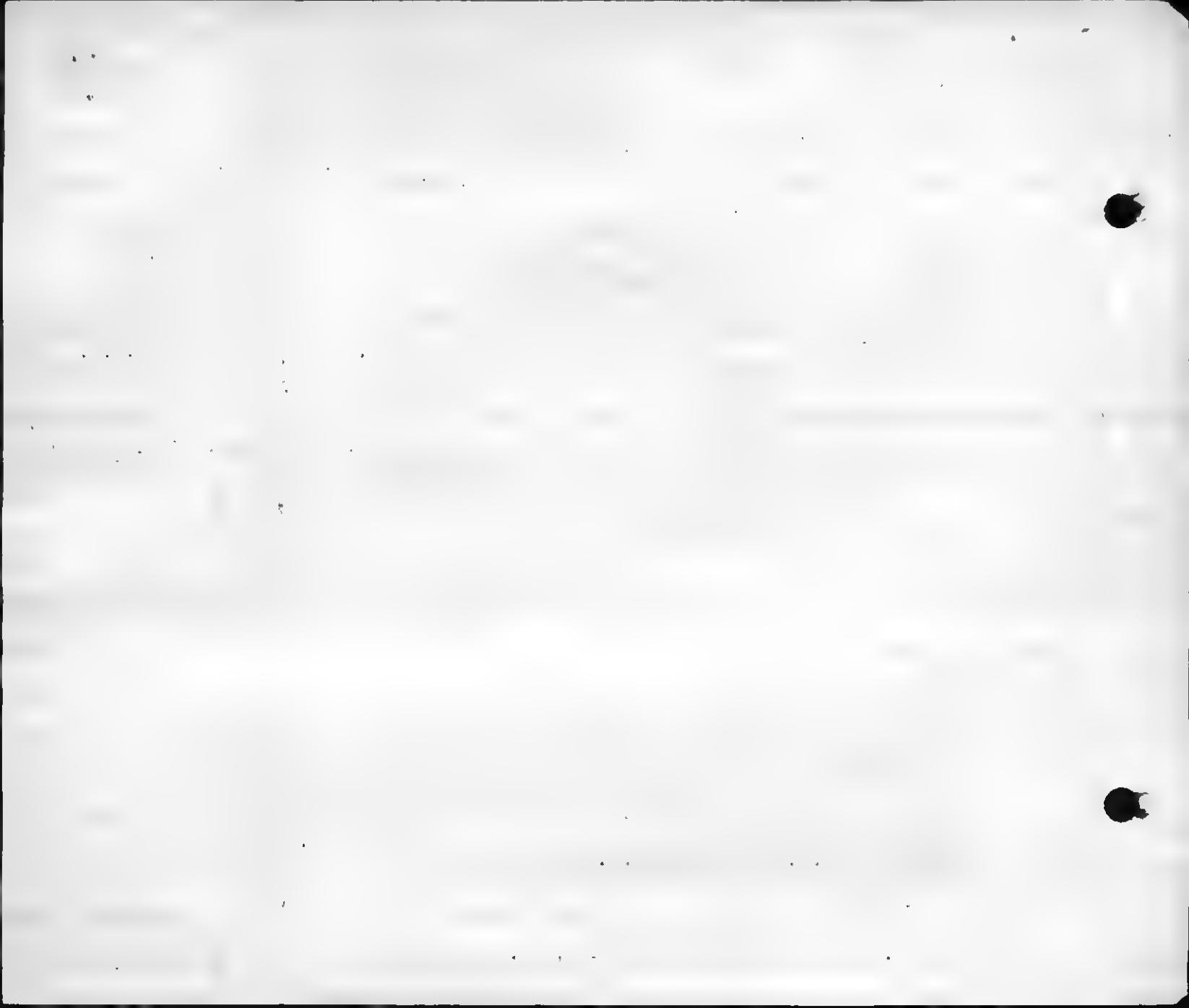
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15677

1. PLACE OF DEATH a. COUNTY frederick		Items 6, 7, 14, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 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427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 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TO HOSPITAL OR TREATING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15676

CERTIFICATE OF DEATH

15678

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Braddock Heights c. LENGTH OF STAY IN lb Since 11/23/66		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vindobona Convalescent & Rest Home		d. STREET ADDRESS 113 Record Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELEANOR	Middle NELSON	Last RITCHIE
4. DATE OF DEATH	Month November	Day 26	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 March 1874
9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME John Ritchie		14. MOTHER'S MAIDEN NAME Betty Maulsby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No	16. SOCIAL SECURITY NO. 220 46 1407	17. INFORMANT Philip R. Winebrenner (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Minutes Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 11/16 1966 , and that death occurred at 3:28 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 28 Nov 1966	
22a. SIGNATURE James B. Thomas,		22b. ADDRESS 228 N. Market St., Frederick, Md. 21701	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery
23d. LOCATION (City, town or county) Frederick, Md. 21701		(State)	
24. FUNERAL DIRECTOR Frank R. Smith Jr.		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701	
25a. REC'D BY REGISTRAR NOV 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15677

CERTIFICATE OF DEATH

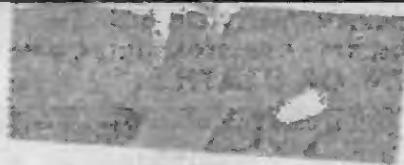
15679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
Frederick		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. LENGTH OF STAY IN lb years		b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Point of Rocks	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Nov. Day 24 Year 1966
Female		White		Wright	5. SEX
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 19- 1888	9. AGE (in years at birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Dey Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Wright		14. MOTHER'S MAIDEN NAME Mary Jane Brown		Address Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7793		17. INFORMANT W. Meredith S. Young- 609 Schley Ave.-Frederick	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 30 MIN.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)		Acute myocardial infarction Arterio-Sclerotic heart dis 15+ yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
p.m. 19					
21. I certify that (I) (this hospital) attended the deceased from 1961, 19, to 24 Nov., 1966, that (I) (we) last saw the deceased alive on 29 Oct. 1966, and that death occurred at 1:15 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Charles H. Conley, Jr.		M.D.		22b. DATE SIGNED Nov. 24-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF Nov. 25-1966		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory	
24. FUNERAL DIRECTOR'S SIGNATURE Elwood T. Whitmore M.R. Etchison & Son		ADDRESS Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE NOV 28 1966	
				25b. REGISTRAR'S SIGNATURE j Charles Judge	

stage



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15678

CERTIFICATE OF DEATH

15680

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>40 Fulton Ave.</i>		d. STREET ADDRESS <i>40 Fulton Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Hulu CLARA Wright</i>		First <i>Hulu</i>	Middle <i>CLARA</i>
4. DATE OF DEATH <i>November 27 1966</i>		Last <i></i>	Month <i>November</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Feb. 1 1905</i>		9. AGE (In years last birthday) <i>61 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesclerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Department store</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Luther C. Putman</i>		14. MOTHER'S MAIDEN NAME <i>K. Gertrude Barton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-01-1298</i>	
17. INFORMANT <i>G.C. Barton, Walkersville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>		<i>2 hours</i>	
DUE TO <i>420.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Coronary thrombosis</i>		<i>2 hours</i>	
} DUE TO (c) <i>Atherosclerotic cardiovascular disease</i>		<i>several years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Factory</i>
20f. (City or town) <i>Walkersville</i>		20g. (County) <i>Frederick</i>	20h. (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>June 1966</i> to <i>Nov. 27 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 27 1966</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
22e. SIGNATURE <i>Ernest A. Dettbarn</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22e. PHYSICIAN'S NAME (Type) <i>ERNEST A. DETTBARN</i>		22f. DATE SIGNED <i>1/28/67</i>	
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23f. DATE THEREOF <i>1/30/66</i>	23g. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Hope cemetery</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton</i>		23h. LOCATION (City, town or county) <i>Woodstock</i>	25e. REC'D BY REGISTRAR <i>Charles Judge</i>
		25f. DATE <i>DEC 1 1966</i>	25g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

12061

12061

DO NOT DESTROY THIS